

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00749  
00744

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>12 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6425 Blenheim Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERBERT OGIER ABURN</b>		4. DATE OF DEATH <b>January 12, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 12, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Manufacturer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Johnson B. Aburn</b>		14. MOTHER'S MAIDEN NAME <b>Minnie F. Stoll</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-7602</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Chronic glomerulonephritis</b> DUE TO (c) <b>Regional enteritis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>		20. 5 years <b>12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>December 31, 1961</b> to <b>January 12, 1962</b> , that (we) last saw the deceased alive on <b>Jan. 12, 1962</b> , and that death occurred <b>11:17AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William B. Kremer</b> M.D.		22b. DATE SIGNED <b>1/12/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>William B. Kremer, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-15-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

(M)

Montgomery

Bethesda

12 days

Baltimore

Baltimore

The Clinical Center

6855 Wisconsin Road

(I)

WINTER

COOL

A UNIT

January

62

Male

September 12, 1960

Transfusion

Manufacturing

Maryland

1961

Johnson E. Brown

Winnie L. Stoll

The National Academy

218-G-7002, The Clinical Center, Bethesda, Md., Maryland

No

Transfusion

1 month

Chronic glomerulonephritis

2 years

Regional enteritis

12 years

x

x

Jan. 12, 62

11:15 AM

January 12, 62

x

William B. Kerner

William A. Kerner, M.D.

The Clinical Center, National Institutes of Health, Bethesda, Md.

Self

Transfusion

11:15 AM

11:15 AM

... January 12, 1962 ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

M

X

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VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 5/1/62 jwk											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Hgts.						b. COUNTY Montgomery					
c. LENGTH OF STAY in 1b 4 mos.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Hgts., Maryland 58					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6015 Walhonding Rd.,						d. STREET ADDRESS 6015 Walhonding Rd.,					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Helen			First C.			Middle Adelman			4. DATE OF DEATH Jan. 20 1962		
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH March 10, 1892		
9. AGE (In years last birthday) 69			IF UNDER 1 YEAR Months Days			IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) New York, N.Y.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Wm. Henry Carlock						14. MOTHER'S MAIDEN NAME Amanda Berrel					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. None			17. INFORMANT Dr. Atelman		
Address 6015 Walhonding Rd.,											
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) History of C.Va. in distant past.											
INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-20-62 Address (Street, city, town, or county)											
ACTUAL SIGNATURE Frank J. Broschart						M.D.					
EXAMINER'S NAME (Type) Frank J. Broschart											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-20-62			22b. DATE THEREOF			22c. NAME OF CEMETERY OR CREMATORY St. Bernards			22d. LOCATION (City, town, or country) (State) Bernardsville, New Jersey		
23. FUNERAL DIRECTOR ROBERT A. PUMPHREY						ADDRESS Bethesda, Maryland			24a. REC'D BY REGISTRAR JAN 23 '62		
						24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00750		00745	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>20 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7117 SYCAMORE AVE.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>7117 SYCAMORE AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence Conduct</u> First Middle Last		4. DATE OF DEATH <u>1</u> <u>30</u> <u>1962</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19, 1880</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK CITY N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHNATHAN D. CONDUCT</u>		14. MOTHER'S MAIDEN NAME <u>EMILY TUTTLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>KATHRINA C. BALDWIN, 29 CRESCENT BL.</u>		Address <u>MADISON N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>uterine carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1960</u> to <u>Jan. 30, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 30, 1962</u> , and that death occurred at <u>5:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Mesimund B Pano, M.D.</u>		22b. DATE SIGNED <u>1/30/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>MESIMUND B PANOS</u>		22d. ADDRESS <u>1726 Eye St. NW, Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>FEB 2, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FLINCOLN CREMATORY</u>	23d. LOCATION (City, town or county) (State) <u>PRINCE GEORGES CO., MD.</u>
24. BURIAL DIRECTOR'S SIGNATURE <u>254 CARROLL ST NW</u>		25a. REC'D BY REGISTRAR <u>FEB 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Krasner</u>			

(M)

00780

University

1911

1111 Spence Ave

Finance Conduct

F. Case

Our Home

Housework

John D. Condict

No

work

Centralized carcinoma metastasis

uterine carcinoma

1111 Spence Ave

20 yrs

1911

March 1880

New York City N.Y.

Early tumor

1914

Station N.Y.

Marion C. Brown, President

Sept 1 1914

3:45 PM

Massachusetts General Hospital

Massachusetts General Hospital

174 Eye St. N.Y.

Operation Feb 2, 1915 (Gross) Prince George's O. H.

1915

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00751

00746

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Derwood R.F.D. #1</u> c. LENGTH OF STAY IN <u>5 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ammons Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney, Maryland</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Harriet</u> First <u>Allen</u> Middle <u>Olney</u> Last			<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>16</u> Year <u>1962</u>				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Col</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>5-10-1880</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mln. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Andrew Burke</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizebeth Wallace</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes give year or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Nursing Home Records</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation.</u> (b) <u>Chronic Myocarditis.</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____					INTERVAL BETWEEN ONSET AND DEATH _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 1, 1961</u> <b>to</b> <u>1/16</u> , 19 <u>62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/15</u> , 19 <u>62</u> , <b>and that death occurred at</b> <u>5:30</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Luciano I. Leal M.D.</u> M.D.			<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> _____		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Luciano I. Leal M.D.</u>			<b>22d. ADDRESS</b> _____				
<b>23a. BURIAL, CREMATION, or other disposition</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/19/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Zion.,</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Mt. Zion, Md.</u> (State) _____		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 18 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Thomas</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be signed by the hospital or attending physician. Part 2 may be signed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>D.C.</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington,</b>	
c. LENGTH OF STAY IN 1b <b>3 yrs. 1 mo.</b>		d. STREET ADDRESS <b>1412 Webster St., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Helen Lyston Aman</b>		4. DATE OF DEATH <b>January 27 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/27/1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lyston</b>		14. MOTHER'S MAIDEN NAME <b>Mary B. Eagan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Benjamin Guy-</b>		Address <b>1001 Tower Building Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>myocardial failure</b> <b>Phumonia</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility - arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 min.</b> <b>4 days</b> <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Disase</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>26 Jan 1962</b> , that (I) <b>we</b> last saw the deceased alive on <b>26 Jan 61</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Horace W. Bernton</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Horace W. Bernton</b>		22d. ADDRESS <b>4743 Bradley Blvd, Chk 15, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1/30/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> ADDRESS <b>2901 14th St. N.W.</b>		25a. REC'D BY REGISTRAR <b>JAN 30 '62</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Conrad S. Hines</b>			

(M)

00752

Washington

1000 Adams Avenue  
Washington D.C. 20004

3 yrs. 1 mo.

Washington

1012 Webster St. N.E.

John Lyndon

January 23

1/27/1970

1012 Webster St. N.E.

25

Washington

1012 Webster St. N.E.

John Lyndon

Harry S. Lyndon

none

Washington D.C.

1001 Tower Building

Washington D.C.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00748

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 1657-2		d. STREET ADDRESS <u>1206 Quebec Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First (Sam) Middle Last <u>Salvatore</u> <u>nmn</u> <u>Amato</u>				4. DATE OF DEATH Month Day Year <u>1</u> - <u>24</u> 19 <u>62</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-1901</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>PALERMO Sicily</u>				12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>			
13. FATHER'S NAME <u>SALVATORE Amato</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Vitale</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) <u>NO</u> <u>NONE</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>Mrs. Salvatore BARRNCA Silver Spring St.</u>				Address <u>1207 QUEBEC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u> <u>?</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-24-62</u> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <u>Frank J. Broschait</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/27/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or country) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Silver Spring Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 29 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

2

M

(m42)

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00755

00750

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brookeville</b> c. LENGTH OF STAY IN 1b <b>2 Mo 11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Russell Rest Home</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring.,</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Cawkard</b>			4. DATE OF DEATH Month Day Year <b>1 12 1962</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1880</b>		9. AGE (In years last birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Presley Aawkward</b>			14. MOTHER'S MAIDEN NAME <b>Luvenia Powell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Luvenia Warren:</b> Address <b>Ashton, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Scrub pulmonary adenocarcinoma</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Adenocarcinoma of the lung</b> DUE TO (c) <b>Adenocarcinoma of the lung</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hrs</b> <b>15 yrs</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1962</b> to <b>Jan 12, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 12, 1962</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>A.D. Bouffant</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>A.D. BOUFFANT</b>			22d. ADDRESS <b>Sandy Spring, Md.</b>		
23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE THEREOF <b>1/17/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Spring.,</b>		23d. LOCATION (City, town or county) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 23 1962</b> DATE <b>JAN 29 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

CERTIFICATE OF DEATH

1975



111

CHRI. S. 1880

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00756

00751

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>34 Wheaton</b>		d. STREET ADDRESS <b>12906 Georgia Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hilda</b> Middle <b>Bessie</b> Last <b>Bacher</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>19 62</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-1883</b> <b>4/15/1893</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months <b>68</b> Days <b>78</b>	IF UNDER 24 HRS. Hours <b>68</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife - own home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fritz Frohardt</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Beyer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hyattsville, Md.</b> <b>Phillip D. Bacher 8506 Allendale Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Asystole</b> DUE TO <b>428.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stokes-Adams Syndrome</b> (c) <b>Coronary Arteriosclerosis, severe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>sudden</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from back porch at home</b>					
20c. TIME OF INJURY Month, Day, Year <b>10:25 xx 1/9 19 62</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wheaton, Mont. Md.</b>		20f. (City or town) <b>Wheaton</b>		(County) <b>Mont.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Frank Broschart</b>		DATE SIGNED <b>1-9-62</b>		Address (Street, city, town, or county) <b>Washington D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>1-11-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or country) <b>Washington</b>		(State) <b>D. C.</b>	
23. FUNERAL DIRECTOR <b>RA Ziska</b> <b>Warner E. Pumprey Inc.</b>		24a. REC'D BY REGISTRAR <b>JAN 15 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>			

MEDICAL CERTIFICATION

00728

(M)

Memorandum

1. Subject

2. Reference

3. Summary

4. Recommendation

5. Remarks

6. Conclusion

7. Signature

8. Date

9. Initials

10. Comments

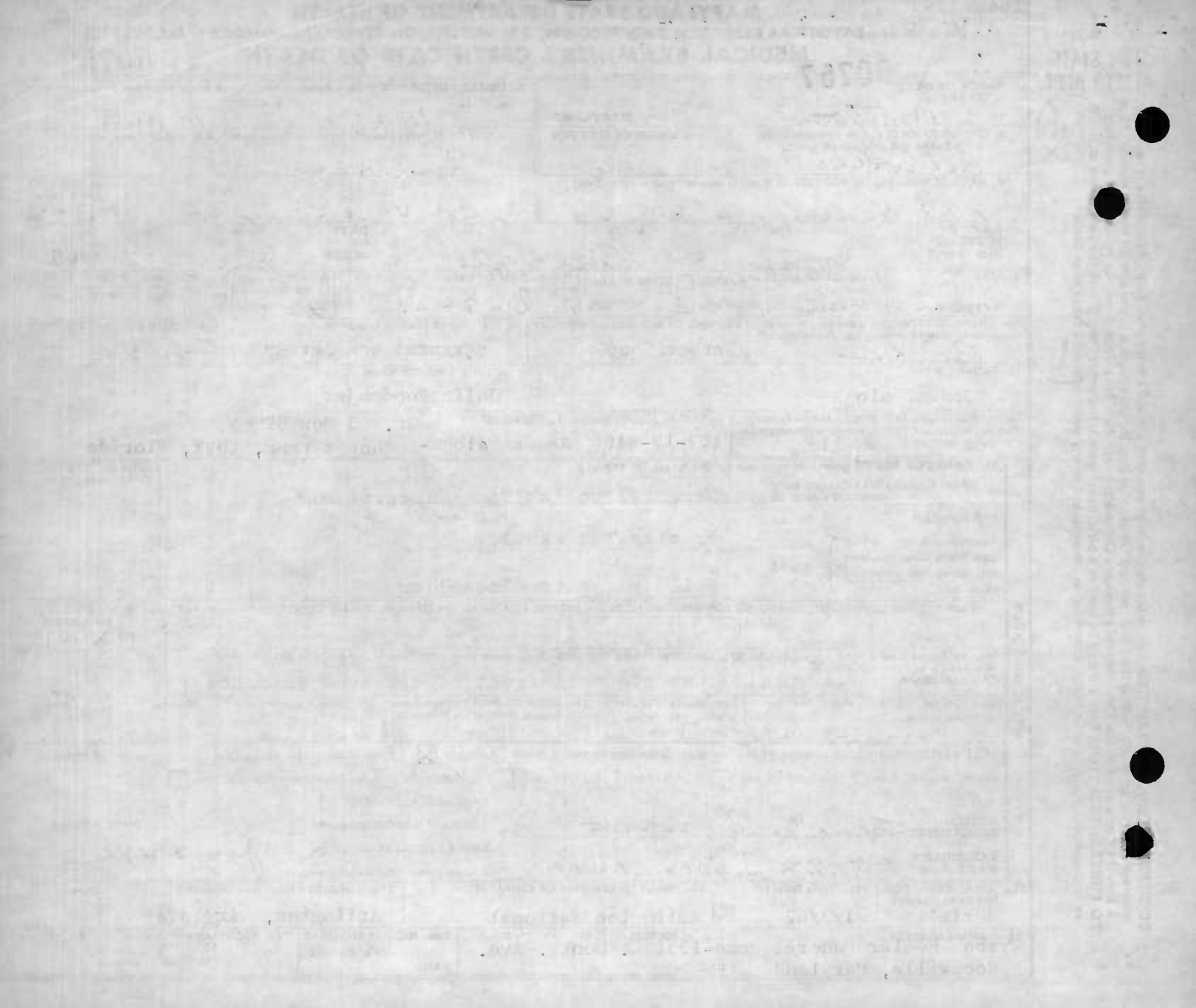
11. Remarks



VS. A1SME  
5M 9/60

00752

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>		d. STREET ADDRESS <u>108 N. Adams st</u>	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>108 N. Adams st.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) <u>John</u>		First Middle Last <u>Balogh</u>		4. DATE OF DEATH <u>Jan 3 1962</u>		Year <u>1962</u>	
	5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-7-21</u>	9. AGE in years last birthday <u>40</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
	13. FATHER'S NAME <u>James Balogh</u>			14. MOTHER'S MAIDEN NAME <u>Julia Popomajer</u>				
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>102-12-6166</u>		17. INFORMANT <u>Rt. # 3 Box 89</u> <u>James Balogh - Sunset Lane, Lutz, Florida</u>			
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral contusions &amp; lacerations</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) <u>Fall and acute alcoholism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u>
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell down steps in front of his home entrance</u>					
	20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>?</u> p.m. <u>1-3</u> 19 <u>62</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Rockville</u>	(County) <u>Montg.</u>	(State) <u>Md.</u>	
	21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: ? Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
	ACTUAL SIGNATURE <u>Frank J. Brosch</u>			M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
	EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Jan 3 1962</u>		
	Address (Street, city, town, or county)							
	22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/8/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u>		(State)	
	23. FUNERAL DIRECTOR <u>Lyson Wheeler Funeral Home-1331 E. Montg. Ave.</u> <u>Rockville, Maryland</u>			24a. REC'D BY REGISTRAR <u>JAN 8 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. **1**

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b. <b>0</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Grimesland</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>70x-3</b> d. STREET ADDRESS <b>Rt #1 Box 168</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William BARBER</b>		4. DATE OF DEATH <b>Jan. 3 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-29 1930</b>
9. AGE (In years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b>	11. IF UNDER 24 HRS. Hours <b>31</b> Min. <b>31</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>	
11. BIRTHPLACE (State or foreign country) <b>Vanseboro, North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. BARBER</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta FOBBS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(S) Bertha L. JONES</b>		Address <b>3191 Stanton Road, S.E. Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basilar Skull Fracture &amp; Laceration of Heart</b> DUE TO <b>902.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Fall from building (3 story)</b> DUE TO (c) <b>902.3</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Interval BETWEEN ONSET AND DEATH Unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Free 3 story fall from construction job - U.S. Naval Hosp.</b>	
20c. TIME OF INJURY Month, Day, Year <b>3-20 p.m. 1-3 19 62</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <b>Construction job</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bethesda monty Md</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschatt</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschatt</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1-4-62</b>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) <b>Greenville, N.C.</b>	
23. FUNERAL DIRECTOR <b>Popes Funeral Home, Washington, D. C.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 8 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

1953

Dr. (Rev.)

Naval Hospital, Bethesda, Maryland

Barry

Harold

Isabel

William H. Davis

Unknown

(3) Brian A. Jones

Full from building (copy)

Greenville, N.C.

Post General, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00759

CERTIFICATE OF DEATH

Reg. Dist. No. 00754

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>13</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		d. STREET ADDRESS <b>Emory Lane</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emory Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Thomas</b> Last <b>Barnsley</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1909</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consignee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sinclair Oil</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Barnsley</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Lett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Hazel Johns, Sister, Olney, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Acute Chronic Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>61</b> , to <b>1/8</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>1/7</b> , 19 <b>62</b> , and that death occurred at <b>12:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, MD</b> DATE SIGNED <b>1/8/62</b> ACTUAL SIGNATURE <b>C. H. Higdon</b> M.D. <b>Sandy Spring, Maryland</b> PHYSICIAN'S NAME (Type) <b>C. H. Higdon</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Friends Meeting House Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

10759

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1880	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. DATE OF DEATH 1945		10. PLACE OF DEATH Home	
11. SIGNATURE OF PHYSICIAN J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris	
13. SIGNATURE OF REGISTRAR J. H. Harris		14. SIGNATURE OF CLERK J. H. Harris	
15. SIGNATURE OF DEPUTY CLERK J. H. Harris		16. SIGNATURE OF ASSISTANT CLERK J. H. Harris	
17. SIGNATURE OF CHIEF CLERK J. H. Harris		18. SIGNATURE OF DEPUTY CHIEF CLERK J. H. Harris	
19. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK J. H. Harris		20. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
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65. SIGNATURE OF CLERK IN CHARGE J. H. Harris		66. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
67. SIGNATURE OF CLERK IN CHARGE J. H. Harris		68. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
69. SIGNATURE OF CLERK IN CHARGE J. H. Harris		70. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
71. SIGNATURE OF CLERK IN CHARGE J. H. Harris		72. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
73. SIGNATURE OF CLERK IN CHARGE J. H. Harris		74. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
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89. SIGNATURE OF CLERK IN CHARGE J. H. Harris		90. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
91. SIGNATURE OF CLERK IN CHARGE J. H. Harris		92. SIGNATURE OF CLERK IN CHARGE J. H. Harris	
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00760

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

000755

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Philadelp Bethesda</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, NIH</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> <span style="float: right;">b. COUNTY <u>✓</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> <span style="float: right;"><u>75x-3</u></span> d. STREET ADDRESS <u>824 North Hilton Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Edward William Barth</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Jan. 25 1962</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 28, 1922</u>		<b>9. AGE</b> (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck-loader</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Carpet</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Steven Barth</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Clara Blakeley</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war/dates of service) <u>yes WWII</u>				<b>16. SOCIAL SECURITY NO.</b> <u>167-18-8697</u>		<b>17. INFORMANT</b> Address <u>Clinical Center, Medical Record</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rheumatic heart disease with</u> (e), stating the underlying cause last. } DUE TO (c) <u>Aortic stenosis &amp; Mitral insufficiency</u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u> <u>  </u> years	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>Died while undergoing surital anesthesia in preparation for heart surgery.</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 1B.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschaw</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <span style="float: right;"><b>DATE SIGNED</b> <u>1-25-62</u></span>					
<b>EXAMINER'S NAME</b> (Type) <u>Frank J. Broschaw</u>				Address (Street, city, town, or county)					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>1/30/62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>NATIONAL CEMETERY</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>BEVERLY N.J.</u>			
<b>23. FUNERAL DIRECTOR</b> <u>W.W. CHAMBERS CO. 1400 CHAPIN ST. NW WASH DC</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 31 '62</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00761

00756

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Silver Spring</b>			
c. LENGTH OF STAY IN 1b <b>3 years</b>				d. STREET ADDRESS <b>1816 Brisbane Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1816 Brisbane Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>THOMAS</b> Middle <b>NOLAN</b> Last <b>BEALL</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>17th</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15th, 1877</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Silver Spring, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		13. FATHER'S NAME <b>Cornelius Beall</b>	
14. MOTHER'S MAIDEN NAME <b>Lucy O'Connor</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>None</b>			
16. SOCIAL SECURITY NO. <b>215-16-1889</b>				17. INFORMANT <b>Wilbur T. Beall, 9209 Saybrook Ave. Sil.Sp., Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO <b>4-20-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 wkr</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>10 Jan 1962 to 17 Jan 1962</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10 Jan 1962</b> to <b>17 Jan 1962</b> that (I) (we) last saw the deceased alive on <b>16 Jan 1962</b> and that death occurred at <b>4:10 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William D. Aud</b>				22b. DATE SIGNED <b>1/17/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>William D. Aud</b>				22d. ADDRESS <b>9008 Colesville Road, Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/20/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery Riggs Rd. Extd., Hyattsville, Md.</b>		23d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers, Inc. Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 25 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

CERTIFICATE OF DEATH

1970

M

Coronary thrombosis  
Atherosclerosis

Hypertension

10 Jan 1970 11:15 AM

William P. [unclear]  
10 Jan 1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00762

00757

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MONTGOMERY</b> c. LENGTH OF STAY IN 1b <b>APROX. 11 HRS.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> d. STREET ADDRESS <b>Rt. 3 Box 307</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES W. BEERS</b>		4. DATE OF DEATH Month <b>1</b> Day <b>4</b> Year <b>1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/10/69</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNSYLVANNIA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. BEERS</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN RICHEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>HOSPITAL RECORDS</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHOPNEUMONIA. with abscess</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio sclerotic heart disease</b> (c) <b>Arteriosclerotic heart disease.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE.</b>		INTERVAL BETWEEN ONSET AND DEATH days <b>yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>11:30A</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/3/62</b> to <b>1/4/62</b> , that (I) (we) last saw the deceased alive on <b>1/4/62</b> , and that death occurred at <b>11:30A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>F. J. Broschart</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>F. J. BROSCART, M.D.</b>		22b. ADDRESS <b>GAITHERSBURG, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-7-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town or county) (State) <b>Gaithersburg Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b> ADDRESS <b>Gaithersburg. Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 8 62</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Ernest C. Gartner</b>	

00762

MONTGOMERY

MARYLAND

MONTGOMERY

CLINT

APRIL 11 1952

WITHERSPOUR

MONTGOMERY GENERAL HOSPITAL

AT 3 Box 307

JAMES

BEERS

HALE

WIFE

110 80

PENNSYLVANIA

RETIRED

GEORGE M. BEARS

ELLEN BEARS

HOSPITAL RECORDS

INTERNAL MEDICINE, WITH HISTORY

ARTERIO SCLEROTIC HEART DISEASE

ARTERIO SCLEROTIC HEART DISEASE

F. J. BROCKWAY, M.D.

WITHERSPOUR, MARYLAND



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01988

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
c. LENGTH OF STAY IN 1b <u>9 yrs</u>				d. STREET ADDRESS <u>6919 Stratmore st</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6919 Stratmore st</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George A. Bentley</u>				4. DATE OF DEATH <u>Jan 31 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-80</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col. U.S.A.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEORGE A. BENTLEY</u>				14. MOTHER'S MAIDEN NAME <u>PLANTE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW 1 &amp; 2</u>				16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>			
17. INFORMANT <u>Marion H Bentley (wife)</u>				Address <u>Stun 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>gsm</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-31-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/5/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>	
				22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u>		(State)	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 7 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

M

GEORGE A BENTLEY / PLANT

Robert A. Thompson, Bethesda, Maryland  
Bentley, George A.  
Bentley, George A.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04258

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6807 Connecticut Avenue</b>				d. STREET ADDRESS <b>6807 Connecticut Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>Louis F Bessey</b>				4. DATE OF DEATH <b>January 5 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1892</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>8</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>				16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>			
17. INFORMANT <b>Mrs. Browning-Step daughter</b>				Address <b>Bethesda, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO <b>1st - 2nd + 3rd degree burns involving about 90% of body</b> DUE TO <b>abuse</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Bed caught afire - Reported smoking in bed.</b>							
20c. TIME OF INJURY Hour a.m. <b>5:15</b> - <b>1-5</b> 19 <b>62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Chevy Chase Monty Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschant</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>1-5-62</b>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>JAN 8 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

(M)

Yes

Unknown

Civil Engineer

Engineer

Engineer

USA

Male

Y

Dec. 27, 1901

Bo

Bo

John

Barney

Barney

8807 Connecticut Avenue

8807 Connecticut Avenue

Army Corps

Army Corps

To Enlist

Enlist

00384 MEDICAL EXAMINER'S CERTIFICATE OF DRAIN

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY in 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Queenstown</b> d. STREET ADDRESS <b>17X-2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Harrison Bishop</b>		4. DATE OF DEATH Month Day Year <b>January 26 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1884</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>78</b>	
11. IF UNDER 24 HRS. Hours Min. <b>78</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Used Car Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
13. FATHER'S NAME <b>William Bishop</b>		14. MOTHER'S MAIDEN NAME <b>Florence Harrison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-7480</b>	
17. INFORMANT <b>Washington Sanitarium and Hospital Records</b>		Address <b>Washington Sanitarium and Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Old Coronary Occlusion</b> (c) <b>Acute Coronary Occlusion</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>terminal</b> <b>? years</b> <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Arteriosclerosis</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While Not While at work at work <input type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19</b>		20f. (City or town) (County) (State) <b>19</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 21, 1962</b> to <b>Jan 26, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 25, 1962</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert A. Hare</b> M.D.		22b. DATE SIGNED <b>1/26/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert A. Hare, M.D.</b>		22d. ADDRESS <b>7600 Carroll Ave, T. Pk, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>Jan 30, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b>		23d. LOCATION (City, town or county) (State) <b>Centreville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Butler Jr. &amp; Butler Son, Centreville, Md.</b> ADDRESS <b>Centreville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

60311

0782



CERTIFICATE OF DEATH

MAINTAINED BY THE DEPARTMENT OF HEALTH

DIRECTOR OF VITAL RECORDS, BUREAU OF VITAL RECORDS, STATE OF NEW YORK

NAME

AGE

SEX

RACE

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CITY

COUNTY

STATE

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

CAUSE OF DEATH

DIAGNOSIS

SYMPTOMS

TREATMENT

PROGNOSIS

DATE OF INTERVIEW

PLACE OF INTERVIEW

CITY

COUNTY

STATE

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

NAME OF MIDWIFE

NAME OF BIRTH ATTENDANT

NAME OF BIRTH ATTENDANT

NAME OF BIRTH ATTENDANT

NAME OF BIRTH ATTENDANT

NAME OF BIRTH ATTENDANT

NAME OF BIRTH ATTENDANT

NAME OF BIRTH ATTENDANT

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00766  
CERTIFICATE OF DEATH  
00760

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>26</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2314 Colston Drive</u>				d. STREET ADDRESS <u>2314 Colston Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cephas</u> Middle <u>Edgar</u> Last <u>Bittinger</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Internal Rev.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chambersburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bittinger</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World War I</u>		17. INFORMANT Address <u>Inez P. Bittinger 2314 Colston Dr. Sil Sp Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho-Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. } DUE TO cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19.53</u> to <u>Jan 28, 19.62</u> that (I) (we) last saw the deceased alive on <u>Jan 28, 19.62</u> and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph H. Watson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan 29, 1962</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-1-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 Ga. Ave., N.W., Wash. DC</u>		25a. REC'D BY REGISTRAR <u>FEB 1 1962</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			

10376



A

June 12, 1908

*Handwritten text, possibly a signature or name.*

*Large handwritten signature or name, possibly "James W. White".*

June 12, 1908

Postmaster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00767

00761

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>4 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>1258 Cresthaven Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>NMN</b> Last <b>Blankenburg</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>23</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-96</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bonds F. ST. N.W. DC</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>	
13. FATHER'S NAME <b>Gottard Blankenburg</b>		14. MOTHER'S MAIDEN NAME <b>Alwine Joch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-32-7865</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac Failure</b> <b>502.0</b> DUE TO <b>ca Pulmonale</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic emphysema</b> (c) <b>&amp; Chronic Bronchitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 24</b> , 19 <b>57</b> to <b>Jan 23</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Dec 29</b> , 19 <b>61</b> , and that death occurred at <b>7:20</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Keithrop Peabody Sr.</b> M.D.		22b. DATE SIGNED <b>1/23/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>1746 K. ST. N.W. WASH. DC</b>		22d. ADDRESS <b>1746 K. ST. N.W. WASH. DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 27 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>JAN 25 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

M

250

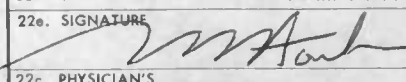
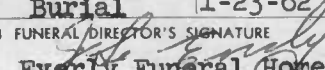
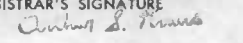
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00768

00762

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Bethesda</b> c. LENGTH OF STAY IN 1b <b>15 minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, NNMC</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY <b>Fairfax</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fairfax</b> d. STREET ADDRESS <b>20 Norman Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Goerge</b> Middle <b>Oliver</b> Last <b>Botts</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>20</b> Year <b>1962</b>											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Cau</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>28 April 1909</b>		<b>9. AGE (In years last birthday)</b> <b>52 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>USN</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Lawyer</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>George R. Botts</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Maggie Brosious</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>				<b>16. SOCIAL SECURITY NO.</b> <b>225-52-5362</b>				<b>17. INFORMANT</b> <b>Wife-Christine M. Botts, 20 Norman Ave., Fairfax, Va.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> (b) <b>ASHD</b> (c) <b>ASHD</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>6 yrs</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)															
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>20 January 1962</b> , to <b>20 January 1962</b> that <b>(H)</b> (we) last saw the deceased alive on <b>20 January 1962</b> , and that death occurred at <b>7:15 AM</b> on the causes and on the date stated above.															
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>V.N. Houk, LCDR MC USN</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <b>U.S. Naval Hospital, Bethesda, Maryland</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>1-23-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>				<b>23d. LOCATION (City, town or county)</b> (State) <b>Arlington, Virginia</b>					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b>  <b>Everly Funeral Home, Fairfax, Virginia</b>						<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b>  <b>DATE</b> <b>JAN 23 '62</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Everett, Franklin Road, Fairfax, Virginia

Barclay 1 1-25-62 Arlington National

Richmond, Virginia

V.H. Houck, ICIR MC UIN

U.S. Naval Hospital, Bethesda, Maryland

20 January 62

7:15 AM

20 January 62

*[Handwritten signature]*

227-22-2362

Wife-Christina M. Houck, 20 Hoxman Ave., Baltimore, Md.

George H. Houck

Wife's Residence

Lawyer

Tennessee

USA

Can

20 April 19 62

January 62

Oliver

House

U.S. Naval Hospital, Bethesda

20 Hoxman Avenue

(Houck), Bethesda

20 minutes

Patricia

Baltimore

Virginia



## CERTIFICATE OF DEATH

00769

0076:2

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Springs</u>		d. STREET ADDRESS <u>9408 Wire Ave</u>	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) <u>John</u>		First <u>William</u> Middle <u>Bowles</u> Last <u>John</u>		4. DATE OF DEATH <u>Jan 1 1962</u>		Day <u>1</u> Year <u>1962</u>	
	5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-04</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>57</u> Days <u>57</u>	IF UNDER 24 HRS. Hours <u>57</u> Min. <u>57</u>	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal Company</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
	13. FATHER'S NAME <u>Warner Bowles</u>			14. MOTHER'S MAIDEN NAME <u>Emma Bowles</u>				
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-3216</u>		17. INFORMANT <u>Pt chart</u>		Address <u></u>	
	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Pulmonary Embolism</u> <u>162-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Brachogenic carcinoma</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 1/2 years</u>	
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1954</u> to <u>Jan 1, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 1 1962</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above								
22a. SIGNATURE <u>Seruch T. Kimble</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-1-62</u>		
22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble, M.D.</u>				22d. ADDRESS <u>927 Pershing Drive, Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> <u>W. E. Humphrey Inc.</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61



00789

IN USE

Direct Point Location

078-0-5210

Section 1, Illinois, I.D.

1-1-62

1-1-62

State of Nevada, Silver County, Nevada  
Silver County, Nevada  
Silver County, Nevada

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00770

00764

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>11/6/61 to 1/19/62</b>			d. STREET ADDRESS <b>1311 Madison St. N.W.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) first Middle Last <b>Katharine E. Bowman</b>			4. DATE OF DEATH Month Day Year <b>January 19 19 62</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>10/30/1884</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Library of Congress U.S.Govt.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>George Bowman</b>			
14. MOTHER'S MAIDEN NAME <b>Louisa P. Cook</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Sanitarium Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours</b> <b>4 Hours</b> <b>2 YRS</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 1961</b> to <b>Jan 19, 1962</b> that (I) <del>was</del> last saw the deceased alive on <b>Jan 17, 1961</b> , and that death occurred at <b>6:45 AM</b> from the causes and on the date stated above.				
22a. SIGNATURE <b>Horace H Custis Jr</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/19/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>HORACE H CUSTIS JR</b>		22d. ADDRESS <b>1852 Columbia Rd NW WASH DC</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2</b>		23b. DATE THEREOF <b>1/23/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		
23d. LOCATION (City, town or county) <b>Washington, D.C.</b>		(State) <b>DC</b>				
24 FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W. Wash</b>		ADDRESS <b>D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 22 '62</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>						

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Washington 11/10/62

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00771

CERTIFICATE OF DEATH

Reg. Dist. No. 00765

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Olney</u>		c. LENGTH OF STAY IN 1b <u>2mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 19</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>901 Prospect Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Wallace</u> Last <u>Boyd</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1962</u>			
5. SEX <u>f</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 30 1881</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wilkerson</u> <u>Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Martha Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Mrs Frances Boyd</u> Address <u>Chry Chase 9md 2602 Spruce Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422</u> IMMEDIATE CAUSE (a) <u>Probable Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>8-10</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>mid July</u> , 19 <u>61</u> , to <u>1/1/62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>12/31</u> , 19 <u>61</u> , and that death occurred at <u>5:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>1/1/62</u> ACTUAL SIGNATURE <u>John P. Martin</u> PHYSICIAN'S NAME (Type) <u>John P. Martin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 4, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Ziska</u> <u>W. E. Pimphrey Inc. 8434 Ga Ave. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

1977

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
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94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	



00772

## CERTIFICATE OF DEATH

00766

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN TB <b>3 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11,504 Lovejoy Street</b>				d. STREET ADDRESS <b>11,504 Lovejoy Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Agnes</b>		Last <b>Braun</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 62</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 30, 1890</b>		9. AGE (In years last birthday) <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Unclebach</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Lewis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>404-36-5999</b>		17. INFORMANT Address <b>Spring, Md.</b> <b>Robert F. Wilbert 11,504 Lovejoy St. Silver</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>MYOCARDIAL INFARCTION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>ARTERIO SCLEROTIC HEART DIS.</b> (c) <b>HYPERTENSION</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 HOURS</b> <b>10 YEARS</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> , 19 <b>62</b> , to <b>1/24</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>1/24</b> , 19 <b>62</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>David Goldenberg</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/25/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>David Goldenberg</b>				22d. ADDRESS <b>10,620 Georgia Ave. Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-27-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town or county) (State) <b>Montgomery Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumfrey, Inc.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 29 '62</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Haines</b>	

MEDICAL CERTIFICATION

Coroner notified and approved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Page 10 of 10

00778

James E. Campbell, Inc.  
Silver Spring, Md.  
1-2-62  
Date of Report  
10, and contain the Silver Spring, Md.

David Robinson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00773

00767

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>7504 Jackson Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. John Aloysius Breen</b>		4. DATE OF DEATH <b>January 1 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 16, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Gov't Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>John Breen</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Droney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Washington Sanitarium and Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>250X Congestive Heart Failure</b> DUE TO (b) <b>Bilateral pulmonary atelectasis with hydrothorax</b> DUE TO (c) <b>Diabetes, Cirrhosis of the liver.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August, 1961</b> , to <b>January 1, 1962</b> ; that (I) (we) last saw the deceased alive on <b>Dec. 31, 1961</b> , and that death occurred at <b>5:09 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Belden R. Reap</b> M.D.		22b. DATE SIGNED <b>JAN. 1, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP</b>		22d. ADDRESS <b>WHEATON, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 3, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Georg Washington Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Adelphi, Pr. Geo. Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b> ADDRESS <b>254 Carroll St. W. Wash, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur E. Howard</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00774

Item 9 Film G305 1/23/62 iwk

00768

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY in lb <b>12 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5510 39th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Alice Reed Bried</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>January 8, 1962</b> Month Day Year		
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>January 11, 1923</b>		<b>9. AGE</b> (In years last birthday) <b>38 39</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New Jersey</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Thomas G. Reid</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ellen F. Sullivan</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>FATHER: Thomas G. Reid, Same as #2</b> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic coma</b> DUE TO (b) <b>Laennec's Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 28</b> , 19 <b>61</b> , to <b>Jan. 8</b> , 19 <b>62</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 8</b> , 19 <b>62</b> and that death occurred at <b>10:55 PM</b> on the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>P. G. Linaweaver</b> M.D.			<b>22b. DATE SIGNED</b> <b>January 9, 1962</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>P. G. LINAWEAVER, LCDR MC USN</b>			<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1-12-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Arlington, Virginia</b>		<b>(State)</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 11 '62</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Timothy Hanlon</b>		<b>ADDRESS</b> <b>WDC</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanna</b>	
<b>Timothy Hanlon Funeral Home, 4748 Wisconsin Ave, NW</b>					



67174

Monogamy

Hechman (Rural)

12 days

U. S. Naval Hospital

Alas

Dead

Wife

January 11, 1943

Female

Canadian

X

Honolulu

Thomas C. Robinson

Allen F. Robinson

New Jersey

US

Examiner: Thomas C. Robinson, Room 22

X

Dec. 20

Jan 8

10:35AM

CS

Jan. 1943

F. G. LINDHART, ROOM NO 221

U. S. Naval Hospital, Bethesda, Md.

Albion National

Albion, Virginia

Timothy Nelson Funeral Home, 420 Wisconsin Ave, NW



TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00775				Item 23b, Film Q306 2/6/62 iwk				00769			
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Florida					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Bethesda						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Green Cove Springs					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS Orangedale Route					
3. NAME OF DECEASED (Type or print) First Middle Last Kevin Lowell BROADWATER						4. DATE OF DEATH Month Day Year January 29 1962					
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 7, 1961		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 22 Days 22 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Kingsport, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lowell Howard BROADWATER						14. MOTHER'S MAIDEN NAME Margaret KILGORE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address (Mother) Margaret Broadwater, Nickelsville, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Congenital Heart Disease Pulmonary Atresia</i> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <i>10 weeks</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 25 January 1962 to 29 January 1962, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 29 January 1962, and that death occurred 4:35 PM from the causes and on the date stated above.											
22a. SIGNATURE <i>James L. Beeby</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 30, 1962			
22c. PHYSICIAN'S NAME (Type) JAMES L. BEEBY LT MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/62		23c. NAME OF CEMETERY OR CREMATORY Nickelsville Cemetery				23d. LOCATION (City, town or county) (State) Nickelsville, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphery</i>				ADDRESS Bethesda, Md. 7557 Wisconsin Ave				25a. REC'D BY REGISTRAR DATE FEB 1 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

9VVVVVV79V

(M)

00372

U. S. Naval Hospital

Naval

Down

November 7, 1917

Memphis, Tenn.

I have received your letter

No

U. S. Naval Hospital, Bethesda, Md.

JAMES H. HENRY JR. MD. LHM

TO HOSPITAL OR AFTER DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00776

00770

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>14 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>20</u> d. STREET ADDRESS <u>8118 Chester st. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Irwin Burneston</u>				4. DATE OF DEATH <u>1 - 5 - 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 - 1 - 95</u> <u>66</u>	
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Burneston</u>				14. MOTHER'S MAIDEN NAME <u>Hall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Hosp. Records</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occ.</u> DUE TO <u>Acute Myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Acute Bronchitis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 hrs.</u> <u>10 1/2 hrs.</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/1962</u> to <u>1/5/1962</u> , that (I) (we) last saw the deceased alive on <u>1/5/1962</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard T Morse MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse MD</u>				22d. ADDRESS <u>7030 Carverview Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-8-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem</u>		23d. LOCATION (City, town or county) (State) <u>Washington DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Funeral Home</u>				ADDRESS <u>4812 9th Ave N.W.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



00713

STATEMENT OF DEATH

George William Johnston  
Male White  
Born 1871  
Died 1913  
Cause of Death  
Buried in  
Cemetery

George William Johnston  
Born 1871  
Died 1913  
Cause of Death  
Buried in  
Cemetery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
00777

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u> 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>Rt. 1 Box 97W.</u>	
3. NAME OF DECEASED (Type or print) <u>Florence Belle Carpenter</u>		4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Dec 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jasper S. Gilbert</u>		14. MOTHER'S MAIDEN NAME <u>Marilla Palmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Charles W. Carpenter-Husband-same 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO <u>450-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile mental deterioration with paranoia</u> DUE TO <u>Arteriosclerosis</u> (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 2, 1948</u> to <u>Jan. 16, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 16, 1962</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Katharine A. Chapman</u> M.D.		22b. DATE SIGNED <u>Jan. 16, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u>		22d. ADDRESS <u>3924 Balto. Ave. Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 19 62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

CERTIFICATE OF DEATH

00777

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Date of registration

11. Name of informant  
12. Address of informant  
13. Signature of informant  
14. Date of completion  
15. Registrar's Office  
16. County of \_\_\_\_\_  
17. State of \_\_\_\_\_



18  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00778

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1403 Crabbe Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leonard Frank Candell, Jr.</u>				4. DATE OF DEATH Month Day Year <u>Jan 20 1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1927</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire &amp; die maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinery</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lenney Candell</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Richardson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>246-283-788</u>		17. INFORMANT Address <u>Betty Candell (wife) Stum 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hemorrhage into Atheromatous Plaque</u> (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DATE SIGNED <u>1-20-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/24/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Sydney Wheeler</u>		23a. REC'D BY REGISTRAR DATE <u>JAN 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

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Montgomery  
Bethesda

DOA

Richardson Hospital

Keen and Frank Campbell

Jan 20 1912

Male White

Altogether

Yes with the exception of the

1911/12 Baltimore  
1912/13 Baltimore  
1913/14 Baltimore

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00779

MARYLAND  
111760

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>77 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Nebraska</b> b. COUNTY <b>Lincoln</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7001 Pioneer Boulevard</b> d. STREET ADDRESS <b>64X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sylvia Ruth Christensen</b> First Middle Last		4. DATE OF DEATH <b>January 23, 1962</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 August 1914</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Mortensen</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Foster</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>The Medical Record,</b> <b>The Clinical Center, Bethesda 14, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis with metastatic abscesses</b> DUE TO (b) <b>Acute myelogenous leukemia</b> DUE TO (c) <b>Bronchopneumonia and pulmonary hemorrhage and edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adrenal hemorrhage.. Thyroid nodule</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 months</b> <b>3 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 7, 1961</b> to <b>January 23, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 23, 1962</b> , and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. David Heywood</b> 22c. PHYSICIAN'S NAME (Type) <b>J. David Heywood</b>		22b. DATE SIGNED <b>January 23, 1962</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 1/23/62</b>		23b. DATE THEREOF <b>1/23/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Lincoln, Nebraska</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 26 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL, OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be completed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Robert A. Emmert, Bethesda, Maryland

Journal - January 1957, Lincoln, Nebraska

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Institution of the United States

January 23, 1957

January 23, 1957

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pensington</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u>		b. COUNTY <u>✓</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pensington Gardens Sanitorium</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 July 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US Army</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
3. NAME OF DECEASED (Type or print) <u>William</u>		First <u>William</u>		Middle <u>H</u>		Last <u>Clifford</u>		4. DATE OF DEATH <u>1</u> <u>25</u> <u>1962</u>		Month <u>1</u>		Day <u>25</u>		Year <u>1962</u>		13. FATHER'S NAME <u>Nathan Clifford</u>		14. MOTHER'S MAIDEN NAME <u>Mabel M. Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>SpAm-WWE</u>		17. INFORMANT <u>Wm. H. Clifford Jr.</u>		Address <u>Fairfax Hotel</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic carcinoma</u> <u>Aortic Stenosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> <u>1960</u> to <u>Jan</u> <u>1962</u> , that (I) <u>we</u> last saw the deceased alive on <u>1/21</u> <u>1962</u> and that death occurred at <u>4:24</u> AM, from the causes and on the date stated above.		22a. SIGNATURE <u>Robert F. Dyer</u>		22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. DYER MD</u>		22d. ADDRESS <u>915 19th St NW Wash DC</u>		22e. REC'D BY REGISTRAR <u>Jan 29 '62</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>26 Jan 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		23e. (State) _____											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		ADDRESS <u>Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>		25. REC'D BY REGISTRAR <u>Jan 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>													

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. [redacted] may be released by the hospital or attending physician.

**REGISTRAR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, [redacted] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 [redacted] could be filled with [redacted] the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

M

Residing at

1000

1000

John G. Clark

John G. Clark

MAILED

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00781		Item 2 Film G306 2/9/62 iwk		00775	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY in b <b>-</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>Dominion Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>M.</b> Last <b>Cole</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>1962</b>		5. SEX <b>female</b>	
6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/17/1878</b>	
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>James Meek</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Carpenter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Acute pulmonary Edema</b> DUE TO <b>Cerebral thrombosis and/or Coronary Occlusion</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>e.m.</b> Month <b>19</b> Day <b>19</b> Year <b>1963</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 27, 1963</b> to <b>Jan. 29, 1963</b> that (I) (we) last saw the deceased alive on <b>Jan. 29, 1963</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Joseph E. Smith, Jr.</b>		22b. DATE <b>Jan. 30, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph E. Smith, Jr.</b>		22d. ADDRESS <b>101 Indian Spr. Dr. Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 1, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION (City, town or county) <b>Washington, D. C.</b>		23e. REC'D BY REGISTRAR <b>FEB 1 '62</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>			

Montgomery

Maryland

Montgomery

Oney Sharon Nursing Home

Oney

Montgomery General Hospital

Jan. 30 02

Cole

Nebraska

Daisy

12/17/1978

Female white

83

U.S.

Pa.

Wife

Wife

Henrietta Carpenter

James Mack

Hospital Records

Unit 107

to

29

Joseph E. Smith, Jr.

Dec. 1, 1962

Lawrenceville, Ga.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00782

00776

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN 1b <b>34</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3915 Joliet Street</b>			d. STREET ADDRESS <b>3915 Joliet Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>BESSIE</b>			First <b>CONNELL</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sep. 25, 1889</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Aaron Marcus (Deceased)</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Sarah (Deceased)</b>		
16. SOCIAL SECURITY NO. <b>579-03-2525</b>			17. INFORMANT Address <b>Harry Reiness 13411 Dauphine St, Wheaton, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Arteriosclerosis</b> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Has had several coronary occlusions in the past. Essential Hypertension. Generalized Arteriosclerosis.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden Death</b> <b>10 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15, 1961</b> to <b>Jan. 13, 1962</b> that (I) (we) last saw the deceased alive on <b>Dec. 15, 1961</b> , and that death occurred at <b>3:00 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Bertam F. Schaefer</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 13, 1962</b>
22c. PHYSICIAN'S NAME (Type) <b>Bertam F. Schaefer</b>			22d. ADDRESS <b>1780 Massachusetts Ave. N.W. Wash. D.C.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 15, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>	
23d. LOCATION (City, town or county) (State) <b>Falls Church, Va.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b> ADDRESS <b>4217 9th Street N.W., DC</b>			
25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

\$2500

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00783

Items 23 Film G306 2/2/62 iwk

00777

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN 1b

13 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital,

### 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)

a. STATE

D. C.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

1826 Vernon Street, Apt. 47X

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

First

Frederick

Middle

(n)

Last

Cook

### 4. DATE OF DEATH

Month

Day

Year

January 29,

19 62

5. SEX

Male

6. COLOR OR RACE

Negroid

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

March 5, 1890

9. AGE (In years last birthday)

71 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Washington, D. C.

USA

13. FATHER'S NAME

Frederick Cook

14. MOTHER'S MAIDEN NAME

Lee Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

unknown

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (X) (this hospital) attended the deceased from Jan. 16, 1962, to Jan. 29, 1962, that (X) (we) last saw the deceased alive on Jan. 29, 1962, and that death occurred at 7:35 PM on the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

WILLIAM P. BAKER LT MC USN

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

Jan. 30, 1962

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

2.3.62

23c. NAME OF CEMETERY OR CREMATORY

LINCOLN MEM. PARK

23d. LOCATION (County, State)

ARLINGTON, VIRGINIA

24 FUNERAL DIRECTOR'S SIGNATURE

McGuire Funeral Home, 1822 9th St NW Wash., D.C.

25a. REC'D BY REGISTRAR

DATE FEB 2 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physician may be executed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

62783

Montgomery

Rebecca (Riv.)

U. S. Naval Hospital,

Frederick (a)

Cook

Hospital

March 2, 1933

Washington, D. C.

Frederick Cook

Dr. Alexander

Yes

*Handwritten signature*

X

Jan. 10 1933  
1:15 PM

Jan. 10 1933

U. S. Naval Hospital, Bethesda, Md.

WILLIAM F. BAKER JR. M.D.

WILLIAM F. BAKER JR.  
BETHESDA, MARYLAND

WILLIAM F. BAKER JR.

WILLIAM

WILLIAM F. BAKER JR. M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00784

Item 23b, Film G306 2/1/62 iwk

00778

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>3226 9th Street</b> d. STREET ADDRESS <b>3226 9th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>OMAR WILSON COOPER</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 13 19 62</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 MARCH 1917</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S.. NAVY Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS COOPER</b>		14. MOTHER'S MAIDEN NAME <b>LILLIE BURDEN</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>233 37 50</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis, Bilateral, severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bacteremia</b> (c) <b>Fatty metamprphus of Liver</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 12 1962</b> , to <b>Jan. 13 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 13 1962</b> , and that death occurred at <b>1417</b> M, from the causes and on the date stated above.							
21a. SIGNATURE <b>James M. Brown LCDR MC USN</b>		21b. PHYSICIAN'S NAME (Type) <b>JAMES M. BROWN LCDR MC USN</b>		21c. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>			
22a. SIGNATURE <b>Robert J. Murphy</b>		22b. ADDRESS <b>Arlington, Virginia</b>		22c. REC'D BY REGISTRAR <b>JAN 18 '62</b>			
22d. SIGNATURE <b>Arthur L. Kiana</b>		22e. ADDRESS <b>3524 Columbia Pike</b>		22f. REC'D BY REGISTRAR <b>JAN 18 '62</b>			

51

I

2

MEDICAL CERTIFICATION

0078

Virginia

Montgomery

Williams

1 day

Postcard (April)

3225 3rd Street

U.S. NAVAL HOSPITAL, BETHESDA, MD.

JANUARY 15

OMAR WILSON COOPER

21 MARCH 1941

WALL CAVE

UN

U.S. NAVY REPT

WILLIAM BURDEN

THOMAS COOPER

HOSPITAL RECORDS

Providence, Rhode Island, 1940

Bethesda

Early symptoms of liver

X

Jan 15 - 1941

Jan 13 - 1941

U.S. NAVAL HOSPITAL, BETHESDA, MD.

Myrtle Beach

Myrtle Beach

Butler

U.S. NAVAL HOSPITAL, BETHESDA, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00785											
00779											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>						c. LENGTH OF STAY IN 1b <b>Chevy Chase 54</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4415 Bradley Lane</b>						d. STREET ADDRESS <b>4415 Bradley Lane</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Jerome Bradshaw Cowden</b>						4. DATE OF DEATH <b>January 15, 1962</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/1905</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government Work - Supt. G.P.O.</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank B. Cowden</b>						14. MOTHER'S MAIDEN NAME <b>Louise Bradshaw</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <b>yes WWII</b>						16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mignon Smith Cowden-4415 Bradley Lane Chevy Chase, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Cardiac Failure</b> DUE TO (c) <b>Auricular Fibrillation</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 Min</b> <b>4 hours</b> <b>3 years</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aneurysm Left Iliac Artery</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 45</b> to <b>Jan 15</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Jan 15</b> , 19 <b>62</b> , and that death occurred at <b>2:15</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Bradley D. Hodgkins MD</b>											
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <b>BRADLEY D. HODGKINS</b>											
22d. ADDRESS <b>4413 Bradley Lane Chevy Chase Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>											
23b. DATE THEREOF <b>1/18/62</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>National Capitol Memorial Park-Muirkirk, Maryland</b>											
23d. LOCATION (City, town or county) (State) <b>Prince Georges Co., Max Washington 9, D.C.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co. - 2901 14th St., N.W. Washington 9, D.C.</b>											
25a. RECEIVED BY REGISTRAR <b>JAN 18 62</b>											
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>											

00773

00773

London, England

Mr. J. H. D. Jones

10, St. James's Place

London, W. 1

9/1/55

Dear Sir,

I am writing to you in reference to the

letter of the 2nd inst.

which you received from me on the 1st inst.

and in which I informed you that I had

received your letter of the 2nd inst.

and that I had been unable to find the

time to write to you on the 2nd inst.

and that I had been unable to find the

time to write to you on the 2nd inst.

and that I had been unable to find the

time to write to you on the 2nd inst.

and that I had been unable to find the

time to write to you on the 2nd inst.

and that I had been unable to find the

time to write to you on the 2nd inst.

and that I had been unable to find the

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1-19-62 00786 Item 23b, Film G305 1/17/62 iwk 00780											
MONTGOMERY MARYLAND											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>1112 N. Kennebec Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Elizabeth Holland Cox</b>						4. DATE OF DEATH <b>January 19, 1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 17, 1893</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Blue Springs, Mississippi</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Smith</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Rhea</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>- - - -</b>		17. INFORMANT <b>Husband: Max Cox, Same as #2</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, recent</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 8, 1962</b> to <b>Jan. 10, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 10, 1962</b> , and that death occurred at <b>6:05 AM</b> on the causes and on the date stated above.											
22a. SIGNATURE <b>V. N. HOUK, LCDR MC USN</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>January 10, 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>V. N. HOUK, LCDR MC USN</b>						22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 12, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Sange</b> ADDRESS <b>Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.</b>						25a. REC'D BY REGISTRAR <b>JAN 12 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

14

78C

Montgomery

Bedford (Hunt)

2 days

Virginia

Atkinson

U. S. Naval Hospital

Miss N. Kennedy Street

Elizabeth

Holland

Cox

January 10,

August 17, 1893

Canadian

Female

Henewick

Blue Springs, Mississippi

William H. Smith

South River

Handed: Mr Cox, same as 78

No

X

X

X

0:00AM

02

JAN. 10

JAN. 8

02

JAN. 10

02

10 January 10, 1902

V. H. HOOK, LABOR CO. NEW

U. S. Naval Hospital, Bethesda, Md.

Washington National

Atkinson, Virginia

Ives Funeral Home, 2001 Wilson Blvd., Arlington, Va.



TO HOSPITAL, OR AT HOME, OR AT ANY OTHER PLACE. The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R.F.D.#1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>419 Carrollton Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ammons Nursing Home</u>		d. STREET ADDRESS <u>Frederick, Md</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Craddock</u>		4. DATE OF DEATH <u>January 16, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Woodley</u>		14. MOTHER'S MAIDEN NAME <u>Alice (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>*****</u>		17. INFORMANT <u>Nursing Home Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac decompensation</u> 422.2 DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November 1961</u> to <u>Jan 16, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 14, 1962</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Luciano I. Leal</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>		22d. ADDRESS <u>Gaithersburg Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hopehill</u>		23d. LOCATION (City, town or county) (State) <u>Hopehill Frederick, Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 22 '62</u>	
ADDRESS <u>Frederick, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



1938

CERTIFICATE OF DEATH

Registration

Lawrence

Age

Occupation

112 West 12th Street

St. Paul

March 11, 1938

Deceased

Married

John J. Lawrence

Married

Age

112 West 12th Street

x

Age

112

St. Paul

March 11, 1938

(Signature)

Witness

Alfred H. Lawrence

Funeral Home

St. Paul

112

March 11, 1938

March 11, 1938

John J. Lawrence

March 11, 1938

March 11, 1938

March 11, 1938

Funeral Home

St. Paul

March 11, 1938

Frederick, Md.

March 11, 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be removed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>2770 BELMONT ROAD N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>C</b> Last <b>CURTIS</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>28</b> Year <b>19 62</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/23/03</b>	
9. AGE (In years last birthday) <b>58 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cirrespondance Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Dept.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Jerome J. Casey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Halpine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Son C. Alexander Curtis</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO (b) <b>Bacterial endocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 18, 1962</b> to <b>Jan. 28, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 28, 1962</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>1/28/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO I DONOVAN MD</b>		22d. ADDRESS <b>8218 WISC AVE BETHESDA 14 MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<b>Burial-transit 1-29-62</b>		<b>Cathedral Cemetery</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<b>Scranton, Penna.</b>		<b>Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>FEB 1 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>			

00782

Jan. 18, 1955 Jan. 18, 55

Jan. 2, 52

Serial-1-25-52 Deliberately Destroyed

ROBERT A. THE NEW BEDHEAD, 50.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00789

00783

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>5 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>22 Silver Spring</b>		d. STREET ADDRESS <b>108 Normandy Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmor Sanitarium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>N</b> Last <b>Curtis</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>24</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/4/1881</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>20</b>		IF UNDER 24 HRS. Hours <b>10</b> Min. <b>20</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Andy Shiflett</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Snow</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Son-Earl W. Shiflett-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma of cervix with metastases</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12-15 months</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 12, 1961</b> to <b>Jan. 24, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 24, 1962</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Katharine A. Chapman</b>				M.D. <b>10:30 PM</b>		22b. DATE SIGNED <b>Jan. 24, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Katharine A. Chapman</b>				22d. ADDRESS <b>3924 Baltimore Rd. Kensington, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 1/25/62</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Roseland Park Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Royal Oak, Michigan</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>DATE JAN 29 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Clara P. Hunt</b>			

M

00788

Montgomery

5 days

Silver Springs

108 Howard Drive

Notes

Private

10 50

VA/101

Virginia

Homewife

now retired

Gardner Snow

Home

200-2000 W. Millport Ave. 20

Pharmaceutical Sales Representative  
with experience

Jan 24 62

Aug 12

Pharmaceutical Sales Representative

Government of Georgia

3025 Briarcliff Rd. Marietta, GA

Robert A. Pugh, Bethesda, Maryland

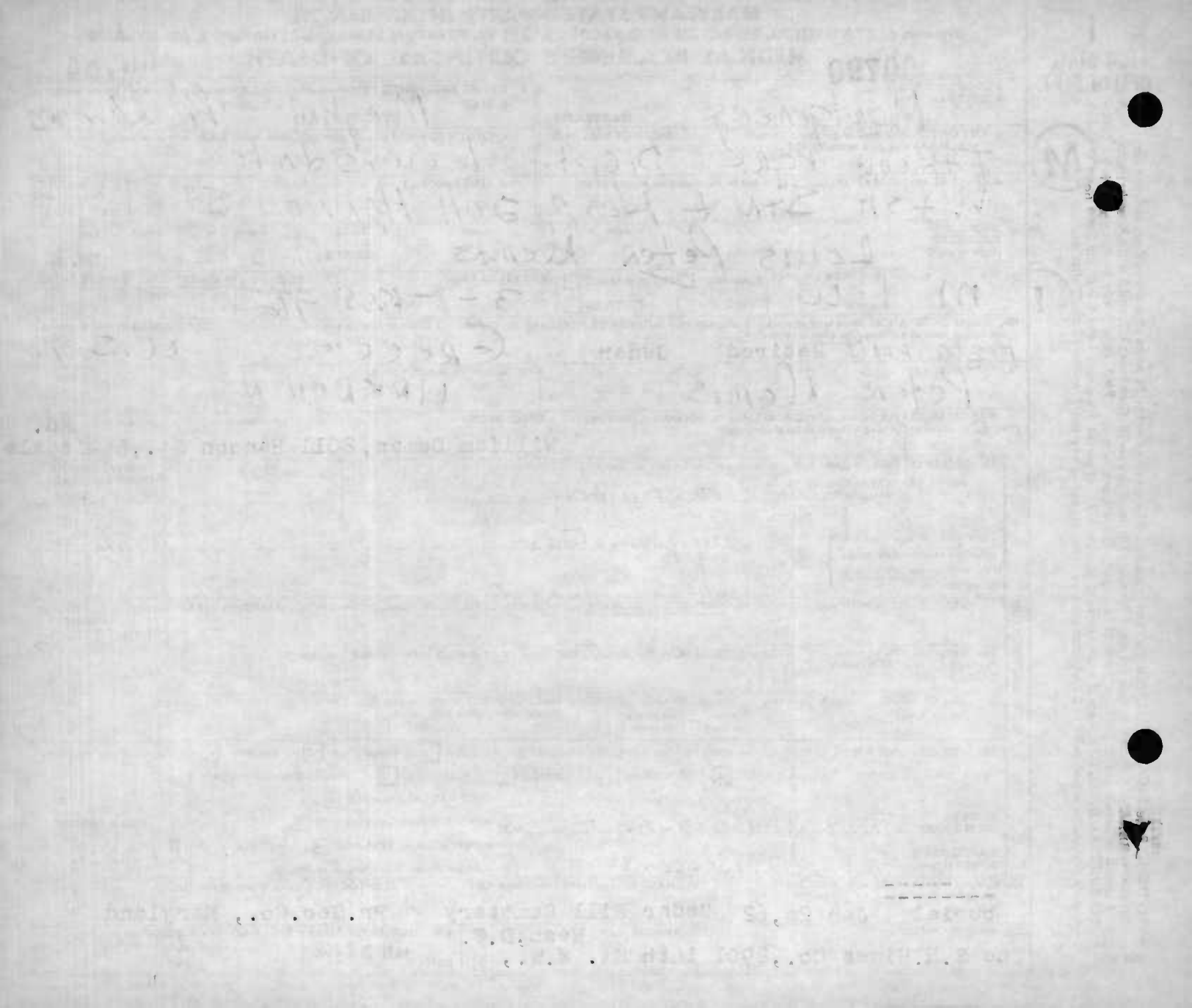
Robert A. Pugh, Bethesda, Maryland



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. Georges</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN It <u>D.O.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u> 1658-2							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Stn &amp; Hosp</u>				d. STREET ADDRESS <u>2011 HANNON ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis Peter Demas</u>				4. DATE OF DEATH Month Day Year <u>1-23-1962</u>											
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-1885</u> 76 yrs.		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>				11. BIRTHPLACE (State or foreign country) <u>Greece</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Demas</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number and dates of service)				17. INFORMANT Address <u>Md. William Demas, 2011 Hannon St., Lewisdale</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertension</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>months</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-23-62</u> Address (Street, city, town, or county)															
ACTUAL SIGNATURE <u>Frank J. Broschatt</u> M.D.				EXAMINER'S NAME (Type) <u>FRANK J. Broschatt</u>											
22a. BURIAL, CREMATION, REMOVAL, OR DISPOSITION <u>burial</u>				22b. DATE THEREOF <u>Jan 26, 62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Pr. Geo. Co., Maryland</u>							
23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>JAN 26 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford A. Hines</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 72 hours after death be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville,</b> d. STREET ADDRESS <b>3902 Beechwood Road,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Unnamed Male Infant Devine</b>		4. DATE OF DEATH Month Day Year <b>January 17, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 17, 1962</b>
9. AGE (In years last birthday) <b>— yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>— — — 25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>Patrick Devine</b>		14. MOTHER'S MAIDEN NAME <b>Rose Mary McKeown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>mother</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Erythroblastosis fetalis</b> DUE TO <b>Rh sensitivity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-17</b> , 1962, to <b>1-17</b> , 1962, that (I) (we) last saw the deceased alive on <b>1/17</b> , 1962, and that death occurred at <b>11:17</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Valgene M. Milstead</b> M.D.		22b. DATE SIGNED <b>1/17/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Valgene M. Milstead, M. D.</b>		22d. ADDRESS <b>1110 Spring St., Silver Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 18, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Waters</b> ADDRESS <b>254 Carroll St. NW, Wash, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 19 1962</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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County

Township

Washington, D.C.

3502 Reservoir Road

Hyattsville

Prince Georges

Hyattsville

Hyattsville

January 11, 1962

62

Male White

x

James H. Hays

no

no

Marland

1962

1962

House Mary

no

no

no

no

110 Spring St., N. W., Washington, D.C.

110 Spring St., N. W., Washington, D.C.

James H. Hays

James H. Hays

62

1962

1962

1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be called by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00792											
00786											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY in lb <u>3mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> 1622-2 d. STREET ADDRESS <u>3400 Senator Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Maude Evans Donlon</u>			4. DATE OF DEATH <u>Jan 15</u> 19 <u>62</u>			5. SEX <u>f</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Feb 4 1873</u>			9. AGE (In years last birthday) <u>88</u> yrs.			IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>N York</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>John Hamilton</u>			14. MOTHER'S MAIDEN NAME <u>Esther Evans</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Miniam Hanley</u>			Address <u>3400 Senator Ave Wash 28</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Intermittent Cardiac Disease</u> DUE TO (c) <u>Intermittent Cardiac Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>19</u> <u>p.m.</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>1/7/62</u> to <u>1/16/62</u> at <u>6:30 pm</u> and that death occurred at <u>1/16/62</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John P. Martin</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/19/62</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>			23d. LOCATION (City, town or county) (State) <u>Albany New York</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Funeral Home</u>						ADDRESS <u>Chapin St. N.W.D.C.</u>			25a. REC'D BY REGISTRAR <u>Arthur E. Hays</u>		
25b. REGISTRAR'S SIGNATURE						DATE <u>JAN 17 '62</u>					

10793

(M)

(1)

John Hamilton  
E. Vanz  
New York

James Henry Jones  
New York  
New York  
New York

Wm. W. W. W.

Wm. W. W. W.



00793

00782

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joshua George Dosh</u>		4. DATE OF DEATH <u>Jan 24</u> 19 <u>62</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14, 1913</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic Plane Aircraft</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Dosh</u>		14. MOTHER'S MAIDEN NAME <u>Eva Pheasant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. J. Dosh</u>		Address <u>305 Ritchie Pkwy</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic H. D.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/62</u> to <u>1/24/62</u> that (I) (we) last saw the deceased alive on <u>1/24/62</u> 19 <u>62</u> and that death occurred at <u>6:15</u> AM, from the causes and on the date stated above.		22a. SIGNATURE <u>Herman C. Maganzini</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u>		22d. ADDRESS <u>509 Veirshill Rd Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 27, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Fyson Wheeler Funeral Home</u> ADDRESS <u>1331-E. Montpelier Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 29 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be signed by the medical or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

CENTRAL OFFICE OF DEATH

1933

TO THE STATE OF TEXAS

IN THE COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this day personally appeared

and acknowledged to me that he executed the foregoing instrument as his free act and deed.

Given under my hand and seal of office this day of

1933.

Notary Public in and for the State of Texas

My commission expires this day of

1933.

Notary Public in and for the State of Texas

My commission expires this day of

1933.

Notary Public in and for the State of Texas

My commission expires this day of

1933.

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 may be retained by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00794  
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>3520 QUESADA STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CAREY B DULANEY</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>28</b> Year <b>1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/7/91</b>	
9. AGE (In years last birthday) <b>70</b> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>PHIL DULANEY</b>			
14. MOTHER'S MAIDEN NAME <b>ALICE WILHART</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>577-05-1761</b>				17. INFORMANT <b>Wife Beulah (Same as above)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary infarct, acute</b> 465X DUE TO (b) <b>Pulmonary thrombosis, right and left pulmonary arteries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>congestive heart failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 23rd, 1962</b> to <b>Jan 28th, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 28th 1962</b> and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.				22a. SIGNATURE <b>Robert Coale</b> M.D.			
22c. PHYSICIAN'S NAME (Type) <b>Robert Coale</b>				22b. DATE SIGNED <b>Jan. 28th. 1962</b>			
22d. ADDRESS <b>4630 montgomery Ave, Bethesda, Md.</b>				22e. REC'D BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-30-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ruckersville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Ruckersville, Va</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Hood-Close-Powell &amp; Son Inc. Fairfax, Va</b>				25a. REGISTRAR'S SIGNATURE <b>Charles E. Hinkle</b>			



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Robert D. ...

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VS. A15ME  
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## MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>11300 Creekshore Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Vincent</b>		First <b>—</b>		Middle <b>—</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		8. DATE OF BIRTH <b>Sept. 21, 1961</b>	
13. FATHER'S NAME <b>Vincent Thomas Durkin</b>		14. MOTHER'S MAIDEN NAME <b>Jean DeAtley</b>		9. AGE (In years last birthday) <b>3</b> yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mr. Vincent Durkin - Father</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>475X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Asphyxia</b> DUE TO <b>supper Respiratory Infection</b>		INTERVAL BETWEEN ONSET AND DEATH <b>found collapsed in bed</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>—</b>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>—</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	
20f. (City or town) <b>—</b>		20g. (County) <b>—</b>		20h. (State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Brosch</b>		M.D. <b>FRANK J. BROSCHE</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHE</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-13-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Montgomery</b>		22e. (State) <b>Maryland</b>		22f. REGISTRAR'S SIGNATURE <b>—</b>	
23. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b>		23a. ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>		23b. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
23c. DATE <b>1-11-62</b>		23d. REGISTRAR'S SIGNATURE <b>—</b>		23e. DATE <b>—</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, fill in 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, fill in 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>District Of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>3138 Stanton Road, S.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>Etta</b> Middle <b>Mae</b> Last <b>Early</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24,</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1907</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>54</b> Days <b>10</b> Hours <b>50</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lily ( Unknown )</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>134.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Aspergillosis, Right upper Lobe</b> DUE TO (c) <b>Acute Myelogenous Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 weeks</b> <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>January 3, 1962</b> , to <b>January 24, 1962</b> that (X) (we) last saw the deceased alive on <b>January 24, 1962</b> , and that death occurred at <b>10:50 P</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Marsh</b> M.D.		22b. DATE SIGNED <b>January 25, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Marsh</b>		22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-29-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM.</b>	23d. LOCATION (City, town or county) (State) <b>SUITLAND MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Plummer</b>		25a. REC'D BY REGISTRAR <b>3015 12th Street, N.E.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>		25c. DATE <b>JAN 29 1962</b>	



Director of Columbia

Washington

1135 Stanton Road, S.W.

Mr. Davis

The National Cancer, Research Institute, Inc.

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Respectfully

May 7, 1907

Dear Sir

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The National Cancer, Research Institute, Inc.

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January 21, 1907

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January 21, 1907

The National Cancer, Research Institute, Inc.

Institute of Health, Washington, D.C.

1135 Stanton Road, S.W.

3015 12th Street, N.W.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10 1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md. D.O.A.</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10514 New Hampshire Ave</u> d. STREET ADDRESS <u>Silver Spring</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Chandler Streeter Eason</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-01</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales MGR. FLEC. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Seth Eason</u>	
14. MOTHER'S MARDEN NAME <u>Alida Streeter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs Nettie Eason - wife</u> Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary insufficiency</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>1-26-62</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>1-29-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>	22d. LOCATION (City, town, or country) (State) <u>Brooklyn, N.Y.</u>
23. FUNERAL DIRECTOR <u>Foley, Connors &amp; FH - Catonsville, Md</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
00792

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>305 Reading Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>IRMINE Irene Edmonds</b>				4. DATE OF DEATH <b>January 4, 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13-1876</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Edmonds Spake</b>				14. MOTHER'S MAIDEN NAME <b>Olive Carr Spake Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Olive Carr-Daughter-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>upper bowel obstruction</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>metastatic malignancy</b> (a), stating the underlying cause last. } DUE TO (c) <b>Carcinoma of colon</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr.</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 Jan., 1962</b> to <b>4 Jan., 1962</b> ; that (I) (we) last saw the deceased alive on <b>4 Jan., 1962</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Stephen N. Jones</b>				22b. DATE SIGNED <b>4 Jan. 62</b>		22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>	
22d. ADDRESS <b>Veirs Mill Rod, Rockville, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/6/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 8 62</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	

00782

205 West 11th Ave.

January 1952

2

Miss Catherine M. Jones

Stephen M. Jones

Rockville, Maryland

Rockville, Maryland

1/1/52

Bar-Jai

Robert A. Humphrey, Bethesda, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> COUNTY <b>Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wheaton Nursing Home</b>		d. STREET ADDRESS <b>7019 Georgia ave. N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Edward J. Ehrmantraut</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>20,</b> Year <b>1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1883</b>
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plate printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward Philip Ehrmantraut</b>		14. MOTHER'S MAIDEN NAME <b>Ada St. John</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>ms. Elizabeth M. Ehrmantraut (same as #2)</b>	
17. INFORMANT <b>ms. Elizabeth M. Ehrmantraut (same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma from Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15</b> , 19 <b>58</b> , to <b>Jan 20</b> , 19 <b>62</b> , that (I) ( <b>no</b> ) last saw the deceased alive on <b>Jan 13</b> , 19 <b>62</b> , and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter K. Angervine</b>		22b. DATE SIGNED <b>Jan 20, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER K. ANGERVINE</b>		22d. ADDRESS <b>6300 - 13<sup>th</sup> ST, N.W., Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 23, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington, DC</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>Jan 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>			

00700

Director of Colonies

Secretary

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Dec. 22, 1883

Mr. [illegible]

Mr. [illegible]

Government

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

to

Mr. [illegible]

Mr. [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

<div> <div>Item 18</div> <div>Form 306</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>00800</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00796</div> </div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3711 811 Duanhoe ST</u> d. STREET ADDRESS <u>Silverspring</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Danielle Christine Falck</u>						<b>4. DATE OF DEATH</b> <u>January 2, 19 62</u>									
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-6-61</u>		<b>9. AGE</b> (In years last birthday) <u>31</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> <tr> <td><u>3</u> <u>25</u></td> <td></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	<u>3</u> <u>25</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months Days	Hours Min.														
<u>3</u> <u>25</u>															
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Erling H. Falck</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Giuffra</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> Address <u>Erling H Falck - Father</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. PENDING</u> <u>Pulmonary congestion &amp; edema</u> (Marked) <u>525X</u> DUE TO (b) <u>Viral Interstitial pneumonitis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Brosch</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>1-2-62</u>									
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____															
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>22b. DATE THEREOF</b> <u>1/4/62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>Prince Georges County, Md.</u>									
<b>23. FUNERAL DIRECTOR</b> ADDRESS <u>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</u>						<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00801

## CERTIFICATE OF DEATH

Reg. Dist. No.

01797

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>45</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 45</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8920 Ridge Place</u>				d. STREET ADDRESS <u>8920 Ridge Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Fay</u> Middle <u>B.</u> Last <u>Farquhar</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lackey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edison Farquhar-son-same 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery occlusion</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December</u> , 19 <u>35</u> , to <u>January 30</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>January 30</u> , 19 <u>62</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Clarence Rice</u> E. CLARENCE RICE, M.D.				ADDRESS (Street, city or town, state) <u>1150 Conn. Ave., N.W., Washington, D.C.</u> DATE SIGNED <u>1/30/62</u>			
PHYSICIAN'S NAME (Type) <u>1150 CONNECTICUT AVE., N.W.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

# CERTIFICATE OF DEATH

1950

MARYLAND STATE DEPARTMENT OF HEALTH - EXHIBIT 12

DECLARATION OF DEATH  
 BY MEDICAL EXAMINER  
 OR  
 BY PHYSICIAN

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF BIRTH _____	
PLACE OF BIRTH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____	
SIGNATURE OF PHYSICIAN _____	
DATE OF DEATH _____	
PLACE OF DEATH _____	
COUNTY _____	
STATE _____	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1949, CHAPTER 233, SECTIONS 1-4, AND 1-5, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1950, CHAPTER 233, SECTIONS 1-4, AND 1-5.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Dr. Frank Broschart contacted + Gave Consent for Dr. Trozzo to sign Certificate

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00802 111794											
1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 21</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>						d. STREET ADDRESS <u>9302 Compton Dr.</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Walter</u>		Middle <u>Henry</u>		Last <u>Ferber</u>		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-22-97</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper Co District of Columbia</u>				11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Louis Ferber</u>						14. MOTHER'S MAIDEN NAME <u>Ida Gordon</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) <u>yes</u> <u>W.W.I. Navy</u>						16. SOCIAL SECURITY NO. <u>578 09 8723</u>		17. INFORMANT Address <u>Mrs Nina M. Ferber - wife</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>  </u> DUE TO (e), stating the underlying cause last. (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Jan</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>1/18</u> , 19 <u>62</u> , and that death occurred at <u>8:00</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank M. Trozzo Jr.</u>						M.D. <u>  </u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M TROZZO JR.</u>						22d. ADDRESS <u>3501 HAMILTON ST HYTS MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 24, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince George Co. Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> <u>Warner E. Pumphrey Inc.</u>						ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

00202

Washington, D.C.  
The Honorable  
The Secretary of the  
Department of the Interior  
Washington, D.C.

Dear Sir:  
I am writing to you  
in regard to the  
matter of the  
Department of the Interior  
Washington, D.C.

I am writing to you  
in regard to the  
matter of the  
Department of the Interior  
Washington, D.C.

Very truly yours,  
Frank M. Tamm  
U.S. Circuit Court of Appeals  
for the First Circuit  
Boston, Mass.

Enclosed for the  
Department of the Interior  
Washington, D.C.  
are two copies of the  
report of the  
Commissioner of the  
Bureau of Land Management  
dated June 1, 1933.

Arthur L. House

VR A15 (4)  
15M 9/60

OR ATTENDING PHYSICIAN: The law requires that the  
may be retained by the hospital or attending physician  
DIRECTOR: After this certificate has been signed

RECEIVED

ARLINGTON CEMETERY

ARLINGTON, VIRGINIA

ROBERT A. PIERCE, BETHESDA, MARYLAND

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00804

00798

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>				d. STREET ADDRESS <i>4319 East West Hwy</i>			
3. NAME OF DECEASED (Type or print) First <i>Alberta</i> Middle <i>M.</i> Last <i>Flack</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>30</i> Year <i>1942</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/4/77</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co., Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Joseph Flack</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Bear</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Bessie B. Branzell</i>				Address <i>4319 East West Hwy Silver Spring, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (b) <i>Cerebrovascular Accident</i> (c) <i>Atherosclerosis, Generalized</i> DUE TO <i>years</i> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Atherosclerotic Heart Disease</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/27/62</i> 19 <i>62</i> to <i>1/30/62</i> 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>1/30/62</i> 19 <i>62</i> , and that death occurred at <i>9:50</i> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Henry C. Scruggs</i>				22b. DATE SIGNED <i>1/30/62</i>		22c. PHYSICIAN'S NAME (Type) <i>Henry C. Scruggs</i>	
22d. ADDRESS <i>7720 Wisconsin Ave. Beth. Md.</i>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/2/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Marys Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				25a. REC'D BY REGISTRAR <i>FEB 6 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thoma</i>	

TO HOSPITAL, PAS-  
death. Pas-  
TO FUNERAL DIRECTOR, PAS-  
director, page 3 should be  
be filed with the State Dept. of Health prior to burial, cremation, or  
removal.

VR A15 (4)  
15M 9/60

(M)

1953

RECEIVED  
JAN 3 1953

Undersecretary of State  
Department of State  
Washington, D.C.  
3000

1/15/53  
1/15/53  
1/15/53

Robert A. Humphrey, Bethesda, Maryland  
2/1/53  
John O. Sweeney  
7730 Macdonald Ave. Baltimore, Md.



00805

## CERTIFICATE OF DEATH

Item 1 Film G305 1/17/62 iwk

00799

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

138

148 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

The Clinical Center, Bethesda 14, Md.

3. NAME OF DECEASED  
(Type or print)

First

Ellis

Middle

Caperton

Last

Flanagan

4. DATE OF DEATH

Month

January

Day

10

Year

19 62

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

December 12, 1892

9. AGE (In years last birthday)

69 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Clerical

11. BIRTHPLACE (County &amp; State, or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Flanagan

14. MOTHER'S MAIDEN NAME

Dora Corroll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

World War I

16. SOCIAL SECURITY NO.

487-07-9234

17. INFORMANT

The Medical Record

Yes World War I 487-07-9234 The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Peripheral Vascular Failure

DUE TO

(b)

Chronic Lymphatic Leukemia

DUE TO

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

7 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.

19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (X) (this hospital) attended the deceased from August 25, 1961 to January 10, 1962, that (X) (we) last saw the deceased alive on January 10, 1962, and that death occurred at 1:34 PM from the causes and on the date stated above.

22a. SIGNATURE

Carl J. Bentzel

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☒

22b. DATE SIGNED

1/11/62

22c. PHYSICIAN'S NAME (Type)

Carl J. Bentzel, M.D.

22d. ADDRESS  
The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

1/12/62

23c. NAME OF CEMETERY OR CREMATORY

Arlington Cemetery

23d. LOCATION (City, town or county)

Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey, Bethesda, Maryland

ADDRESS

25a. REC'D BY REGISTRAR  
DATE

JAN 15 62

25b. REGISTRAR'S SIGNATURE

Arthur S. Harris

00803

Montgomery

Mr.

Subject

Cheney, Chase

Cheney, Chase

Subject

Cheney, Chase Drive

The Office Center, Bethesda, Md.

January 10, 1962

Cheney, Chase Drive

Cheney, Chase

1

Cheney, Chase Drive

Cheney, Chase

Subject

U.S.

Cheney, Chase

Cheney, Chase

Subject

Cheney, Chase

Subject

Cheney, Chase

Cheney, Chase

Cheney, Chase

Cheney, Chase

Subject

Cheney, Chase

Cheney, Chase

U.S.

Cheney, Chase

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Cheney, Chase

Cheney, Chase

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00806

00800

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Garrett Park</u> d. STREET ADDRESS <u>10934 Montrose Ave.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Ann</u> Last <u>Freer</u> 4. DATE OF DEATH Month <u>JAN</u> Day <u>6</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/20/43</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Peter Walker</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Hess</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT Address <u>Charles A Freer (son) same as above.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X Congestive Heart Failure</u> DUE TO (b) <u>Rheumatic Heart Disease and</u> DUE TO (c) <u>Severe Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>? 40 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>None</u> p.m. <u>None</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/3, 1961</u> to <u>1/5, 1962</u> ; that (I) (we) last saw the deceased alive on <u>1/5, 1962</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umrau</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMRAN</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>8805 Conn. Ave. Ch. Md. Md</u> 22b. DATE SIGNED <u>1/6/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-9-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u> 23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>		24. BURIAL DIRECTOR'S SIGNATURE <u>R. A. Ziska</u> <u>4434 Georgia Ave. Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>JAN 11 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>	

M

00000

Peter Walker

Handwritten text, possibly "Handwritten" or "Handwritten"

George Washington  
Washington  
George Washington  
George Washington  
George Washington

11.2.2

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

361  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00807

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00801

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Dist of Columbia</u> b. COUNTY <u>Dist of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC 47x3</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.O.A.</u>				d. STREET ADDRESS <u>1356 Iris St NW</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH STN + HOSP</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Thomas Gable</u>				4. DATE OF DEATH <u>1-11-1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-31-90</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>62</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>us. kept at war</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>us. kept at war</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Gable</u>				14. MOTHER'S MAIDEN NAME <u>Agnes King.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>same as above</u>			
17. INFORMANT <u>Mrs. Alma S. Gable</u>				Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>MITRAL INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>410X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>FRACTURE, LEFT 10<sup>th</sup> RIB, AXILLARY LINE</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while driving at intersection</u>			
20c. TIME OF INJURY Hour <u>10:25</u> p.m. Month, Day, Year <u>12-30-1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>street</u>		20f. (City or town) <u>Admission Mary Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bioschank</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BIOSCHANK</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-12-62</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>15 JAN. 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or country) <u>ROCKVILLE MD.</u> (State)	
23. FUNERAL DIRECTOR <u>Michael J. Lisacki</u> ADDRESS <u>1740 GEORGETOWN AVE NW</u>				24a. REC'D BY REGISTRAR <u>JAN 15 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.



## CERTIFICATE OF DEATH

Reg. Dist. No. 01802

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 1, Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>715 Lenmar Ave. Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Rest Home</u>		d. STREET ADDRESS <u>715 Lenmar - 23A</u>	
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>S.</u> Middle <u>Gaither</u> Last		4. DATE OF DEATH <u>Jan.</u> Month <u>22</u> Day <u>1962</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR <u>66</u> Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hodge</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lynn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-24-1135</u>	
17. INFORMANT <u>George Gaither, son</u>		Address <u>715 Lenmar - 23A Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>445X</u> DUE TO (b) <u>Malignant Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>many years</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, Somatic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>60</u> to <u>1-20</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>62</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Martin Lane Rockville, Md.</u> DATE SIGNED <u>1-23-62</u>			
ACTUAL SIGNATURE <u>Clive E. Jackson</u> , M.D.		PHYSICIAN'S NAME (Type) <u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF <u>1/25/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion,</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowler</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 26 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Plank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 9/60

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00809 CERTIFICATE OF DEATH 00803											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>327 - F. ST. WASH. D.C.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BELMONT NURSING HOME</u>						d. STREET ADDRESS <u>327 - F. ST. N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Giorgio</u> First <u>GIANCOLI</u> Middle <u>GIANCOLI</u> Last		4. DATE OF DEATH <u>JAN - 2</u> 19 <u>62</u> Month Day Year									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 15, 1899</u> 62 yrs.		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WILLARD Hotel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>				12. CITIZEN OF WHAT COUNTRY? <u>ITALY</u>	
13. FATHER'S NAME <u>JOSEPH GIANCOLI</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE LAZZARI</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>VALENTE GIANCOLI</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>cerebral embolism</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic hd disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> <u>? day</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov., 1961</u> , to <u>1/2/1962</u> , that (I) (we) last saw the deceased alive on <u>12/20/1961</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>D. Nelson</u>				M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/2/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>D. NELSON</u>				22d. ADDRESS <u>10670 GA. AVE. Sic. Sp. Mo</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/6/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem,</u>				23d. LOCATION (City, town or county) <u>Washington, D.C.</u> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 300-4th St. N.E. Wash. D.C.</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>C. Long S. Thomas</u>			

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CERTIFICATE OF DEATH

(M)

(T)

D. Nelson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2918 Legation St., N.W.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry Albert GILTNER</b> First Middle Last		4. DATE OF DEATH <b>January 16 1962</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 November 1878</b> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Naval Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>83</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin L. Giltner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Luiza Mount</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Mrs. Virginia B. Giltner</b>	
17. INFORMANT <b>Mrs. Virginia B. Giltner</b>		Address <b>2918 Legation St. NW Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>420.0 Uremia</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerotic heart disease and generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Washington</b>		(County) <b>District of Columbia</b>	
(State) <b>District of Columbia</b>		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 2</b> , 19 <b>62</b> to <b>Jan. 16</b> , 19 <b>62</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 16</b> , 19 <b>62</b> , and that death occurred at <b>2:20 PM</b> on the causes and on the date stated above.	
22a. SIGNATURE <b>Larry J. Hines</b> M.D.		22b. DATE SIGNED <b>January 17, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>LARRY J. HINES, CDR MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-19-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b> ADDRESS <b>S.H. Hines Funeral Home, 2901 14th. St. NW WDC</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 19 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>William L. Hines</b>			

0210



Management

Nebraska (Rural)

13 days

Washington

U.S. Naval Hospital, Bethesda, Md.

2nd Hospital, W.D.

Health

Alfred

Clinton

January

Male

Good

6 November 1918

Nebraska Naval Officer

Indiana

Marion A. Glicker

Garrett Lake, Mont.

Two Virginia B. Glicker

2nd Hospital, W.D.  
Washington, D.C.

Yes

X

Jan 2

Jan 10

2:25 PM

1-10-18

OK January 14, 1918

U.S. Naval Hospital, Bethesda, Md.

LARRY J. HINES, CMDR MC USN

Washington National

1-10-18

Hines

Virginia

U.S. Hines (Rural) 1901 1918. W.D.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director, who should be designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>C &amp; O Canal</u>		d. STREET ADDRESS <u>5511 Barling Ct</u>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>H.</u> Last <u>Godine</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-1906</u>			
9. AGE (in years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Life Insurance</u>			
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Godine</u>		14. MOTHER'S MAIDEN NAME <u>Belle Prime</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-8923</u>			
17. INFORMANT <u>Lucille Godine-Wife-same above</u>		Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 DUE TO <u>(Collapsed while ice skating)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21. ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. <u>  </u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/15/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
22d. LOCATION (City, town, or country) <u>Suitland, Maryland</u>		22e. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		DATE <u>JAN 16 '62</u>	

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General Agent

Life Insurance New Jersey

William G. G. G.

Life Insurance

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(Continued on next page)

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TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Payment may be made by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00812

00806

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>DADE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>miami Springs</u> d. STREET ADDRESS <u>64th Ave. 3940 N. West</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) <u>Florence Mary Cullen Golsen</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>2</u> Year <u>1962</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-29-97</u>		9. AGE (In years last birthday) <u>64 yrs.</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auditor (RET.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Home &amp; Finance</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>																			
13. FATHER'S NAME <u>albert J. Cullen</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Krall</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>								16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Sanitarium Records</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive bleeding Duodenal ulcer</u> 541.10 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>																INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 20, 1961</u> to <u>Jan 2, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 2, 1962</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.																															
22a. SIGNATURE <u>Robert A. Hare</u>				M.D. <u></u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>1/3/61</u>																			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD.</u>				22d. ADDRESS <u>7600 Carroll Ave. T.P. Md</u>																											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-5-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>																			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond L. Ziska</u>				434 ADDRESS <u>Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>JAN 5 '62</u>				25b. REGISTRAR'S SIGNATURE <u>John L. Hare</u>																			
W.S. Humphrey Inc.				Silver Spring, Maryland																											

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CERTIFICATE OF DEATH

Reg. Dist. No. 111807

00813

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 45</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>6505 Greentree Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Lipstein</u> Last <u>Greenfeld</u>		4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Simon Lipstein</u>		14. MOTHER'S MAIDEN NAME <u>Tamara Kaplan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Sidney H Greenfeld</u> Address <u>Same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Asthma (2) upper respiratory infection (3) arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/8/62</u> , 19____, to <u>1/29/62</u> , 19____, that I last saw the deceased alive on <u>1/28/62</u> , 19____, and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Patrick C Jameson</u> M.D.		ADDRESS (Street, city or town, state) <u>12020 Georgia</u>	
PHYSICIAN'S NAME (Type) <u>Patrick C Jameson</u>		DATE SIGNED <u>1/29/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Euteria Place</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 31 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00808

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>63 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>83x-3</b> d. STREET ADDRESS <b>2402 Menokin Drive, Apt. 103</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen Mae Greiner</b>		4. DATE OF DEATH Month Day Year <b>January 18, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1904</b> 9. AGE (In years last birthday) <b>57 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Minn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph B. Moore</b>	
14. MOTHER'S MAIDEN NAME <b>Hetty P. Kelly</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT <b>HUSBAND: James L. Greiner, Same as #8</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> DUE TO (b) <b>Pulmonary Metastases</b> DUE TO (c) <b>Carcinoma of Cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>5 mos.</b> <b>20 mos.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b> <b>20 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>Nov. 16, 1961</b> to <b>Jan. 18, 1962</b> that (we) last saw the deceased alive on <b>Jan. 18, 1962</b> and that death occurred at <b>2:53AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Louis E. Potvin</b> M.D.		22b. DATE <b>January 18, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS E. POTVIN, LCDRMC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>1-18-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>	23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee's Funeral Home, 4th &amp; Massachusetts Ave. NE</b> <b>By E. St. Foster</b>		25a. REC'D BY REGISTRAR <b>JAN 22 '62</b> <b>Arthur S. Hume</b>	

TO HOSPITAL, OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. after death, page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00014

M

1

Montgomery

Belmont (Rural)

U. S. Naval Hospital

Helen

Conover

Female

Hennepin

Joseph E. Moore

No

HUSBAND: James L. Granger, June 28, 1902

Harry F. Kelly

Male

April 28, 1904

Greider

January 28, 1902

Albany

Virginia

CENTRAL OF DEATH

X

Jan. 18, 02

Nov. 10, 01

Jan. 18, 02

ROUTE 2, FORT, FORT MONROE, VA.

U. S. Naval Hospital, Baltimore, Md.

Commission 1-18-02

IA - Crumpton

Washington, D. C.

WIC

John A. Fitzgerald, 4th & Massachusetts Ave., N.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00815  
00809  
00809

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bensington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL Hall Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wilkinsburg</u> 75X-3 d. STREET ADDRESS <u>721 Midland St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Valerie</u> First <u>HAGARA</u> Middle Last 4. DATE OF DEATH <u>Jan. 5</u> 19 <u>62</u> Month Day Year		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 20, 1878</u> 83 yrs.		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Alexander Hagara, AS ABOVE</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerosis</u> (e), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonitis</u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4 1962</u> to <u>Jan 4 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 4 1962</u> , and that death occurred at <u>12:45 PM</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Alfred S. Norton</u> M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Alfred S. Norton, M.D.</u>								22d. ADDRESS <u>4711 Highland Ave., Bethesda 14, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/8/62</u>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <u>Chunehin Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Wilkinsburg, Pa.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. C. Kree, 800 Center St, Pgh 21</u>								25a. REC'D BY REGISTRAR <u>Jan 10 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>					



00212

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1962" and "11/8/62" are faintly visible.]*

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Physicians may be examined by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00816

00810

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>10 1/2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1508 Windham Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Beverly WAITE Hardy</u>				4. DATE OF DEATH <u>JAN. 7 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 30 1916</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TYPIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Raymond Waite</u>				14. MOTHER'S MAIDEN NAME <u>MARJORIE Thurnett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>William Hardy (husband)</u> Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Hepatic Coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cirrhosis liver</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/59</u> , 19 <u>59</u> , to <u>Jan 7</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan 6 1962</u> and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Patrick C. Jameson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>PATRICK C. JAMESON</u>				22d. ADDRESS <u>12020 Georgia Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 10, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Geo. Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>Silver Spring</u>		25a. REC'D BY REGISTRAR <u>Warner E. Humphrey, Inc., Md.</u>	
				DATE <u>JAN 11 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	

M

Montgomery

Bethesda

Suburban Hospital

100 days

Beverly WHITE

Female white

TYPEST

U.S. Gov't

Raymond White

Maryland

Silver Spring

1208 Wintham Lane

Hardy

2m.

Sept 30 1916 40

U.S.A.

Illinois

MARJORIE

William White (husband)

PATRICK C. JAMESON

Box 10, 1102 2nd Street  
Washington, D.C.  
20002-2

County, Kansas



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>2319 Savannah Street, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Rose Elizabeth Hargrove</b>				4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>19 62</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 18, 1937</b>		9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>				11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wesley Gilbert</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Fennell</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>				17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subacute bacterial endocarditis - mitral valve</b> 410 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Rupture of chordae tendinea, mitral valve</b> DUE TO (c) <b>Mitral insufficiency</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/20/62</b> Address (Street, city, town, or county)											
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/25/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or country) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>John T. Phibes Co.</b>				ADDRESS <b>3015-12th St. NE</b>				24a. REC'D BY REGISTRAR <b>JAN 26 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

(M)

District of Columbia

Washington

21 days

Refused

209 Savannah Street, S.W.

The Clinical Center, Bethesda, Md.

62

60

January

January

February

June

December 18, 1937

June

June

U.S.A.

Washington, D.C.

Washington

Practical nurse

Necky Gilbert

Barth's Tunnel

the Medical Record

Unobtainable the Clinical Center, Bethesda, Md.

2/20/62

Trans. J. Broderick, N.Y.

William National Center, Washington, D.C.

William National Center, Washington, D.C.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7(6)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00818

CERTIFICATE OF DEATH

Item 10b, film G306 2/2/62 iwk

00818

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5300 Westbard Avenue</b>				d. STREET ADDRESS <b>5300 Westbard Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>George J. Harris, Sr</b>				4. DATE OF DEATH <b>Jan. 18 19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 14, 1906</b>	
9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR <b>0</b> Months <b>4</b> Days		IF UNDER 24 HRS. <b>0</b> Hours <b>4</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assist. V. Pres. American Railway</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Washington D. C.</b>			
13. FATHER'S NAME <b>George W. Harris</b>				14. MOTHER'S MAIDEN NAME <b>Mary Taylor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW 2</b>				16. SOCIAL SECURITY NO. <b>578-05-2132</b>			
17. INFORMANT <b>Beulah Harris-Wife-same 2d</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (U) (this hospital) attended the deceased from <b>Oct. 30 19 59</b> to <b>Jan. 18 19 62</b> , that (U) (we) last saw the deceased alive on <b>1-17-62</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. William S. Detwiler</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/18/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William S. Detwiler</b>				22d. ADDRESS <b>418 - 1025 Conn. Ave. NW Washington, DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/22/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

00012

Montgomery

Alabama

Montgomery

Alabama

2200 Westport Avenue

2200 Westport Avenue

George

George

Male

White

Jan 19 1900

Assistant V. B.

Assistant V. B.

George V. Harris

George V. Harris

Yes

Yes

Yes

Unknown to Bureau Harris - was in

Montgomery, Alabama

22 371

1-10-02

1-10-02

Dr. William B. Gentry

413 - 1005 Comm. Ave. NW Washington, DC

Bureau

1/22/02

Arlington Cemetery

Washington, Virginia

Robert A. Pumphrey

Robert A. Pumphrey

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>300 Normandy Drive</b>		d. STREET ADDRESS <b>300 Normandy Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Hester</b> Middle <b>Bruce</b> Last <b>Harris</b>		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 62</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/3/1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>22</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Perkins</b>		14. MOTHER'S MAIDEN NAME <b>Ella Pollard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Thomas C. Vickers</b>		Address <b>300 Normandy Dr. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. <b>Diabetes</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 23 1962</b> to <b>Jan 23 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 23 1962</b> , and that death occurred at <b>10PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John N. Andrews</b>		22b. DATE SIGNED <b>1-23-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>		22d. ADDRESS <b>9601 Colesville Rd Silver Spring Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/26/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>JAN 25 '62</b>	
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00820

00814

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 53</u>	
c. LENGTH OF STAY in 1b <u>2 1/2 yrs</u>		d. STREET ADDRESS <u>24 W Irving ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaretha W. Harris</u>		4. DATE OF DEATH Month Day Year <u>January 2 1962</u>	
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 13 1873</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dr Lewis H. Harris</u>		14. MOTHER'S MAIDEN NAME <u>Frances C Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>E &amp; E Ellis</u>		Address <u>24 W Irving ST md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446 X</u> DUE TO <u>Chronic Nephritis (urine)</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis Generalized</u> (e), stating the underlying cause last. DUE TO (c) <u>Yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1959</u> to <u>1/2 1962</u> , that (I) (we) last saw the deceased alive on <u>12/29 1961</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>O. H. Ligon</u> M.D.		22b. DATE SIGNED <u>1/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>O. H. Ligon</u>		22d. ADDRESS <u>Sandy Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/2/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00815

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clney</u>			c. LENGTH OF STAY in 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Laytonsville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg General Hosp</u>					d. STREET ADDRESS <u>1</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Toney Antonio Hawkins</u>					4. DATE OF DEATH Month Day Year <u>Jan 15 1962</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-22-61</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. <u>3 23</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Karleton Hawkins Lee</u>					14. MOTHER'S MAIDEN NAME <u>Mary Hawkins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mary Hawkins - June 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-7-5X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (b) <u>upper Respiratory Infection</u> (a), stating the underlying cause last. (c) <u>found collapsed in bed</u>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Frank J. Broschart</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-15-62</u>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)										
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>			22b. DATE THEREOF <u>1/18/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park..</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>			ADDRESS <u>Rockville, Md.</u>			24a. REC'D BY REGISTRAR <u>JAN 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be reviewed by the funeral director or attending physician and completely filled in by the funeral director, or by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00822

00816

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>4 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12902 Holdridge Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jessie Josephine</b> Middle <b>(England)</b> Last <b>Henry</b>		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>12</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Payne England</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Legg</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Francis O'Connor-Daughter-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atelectasis</b> DUE TO (c) <b>Cerebral thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsonism</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1962</b> to <b>Jan 22, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 21, 1962</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Blaine H. EIC.</b>		22b. DATE SIGNED <b>1/22/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>BLAINE H. EIC.</b>		22d. ADDRESS <b>8641 Colson Rd Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/23/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

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## CERTIFICATE OF DEATH

Reg. Dist. No.

00823 111817

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>44 Bethesda</b>	
c. LENGTH OF STAY IN 1b <b>5 years</b>		d. STREET ADDRESS <b>10103 Dickens Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10103 Dickens Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Arthur</b> Middle <b>Hill</b> Last		4. DATE OF DEATH <b>January</b> Month <b>19</b> Day <b>1962</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1889</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR: Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hearing Aid Business - Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Hill</b>		14. MOTHER'S MAIDEN NAME <b>Alexandria McLean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>292-07-4078</b>	
17. INFORMANT <b>Anna Marie Hill</b> Address <b>10103 Dickens Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstructive Renal Failure</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Prostate</b> DUE TO (c) <b>2 years +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept.</b> , 19 <b>61</b> , to <b>present</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>January 8</b> , 19 <b>62</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Gustafson</b>		ADDRESS (Street, city or town, state) <b>915 19th Street, N.W. Washington 6, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN F. GUSTAFSON</b>		DATE SIGNED <b>Jan. 19, 1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>1-19-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 23 '62</b>	
		24b. REGISTRAR'S SIGNATURE <b>Clifford J. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <b>Suburban</b> <b>Montgomery</b> <b>MARYLAND</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Washington D.C.</b> b. COUNTY <b>Washington D.C.</b>
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b <b>15 hours</b>
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery Co Suburban Hosp.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	3. NAME OF DECEASED (Type or print) <b>Charles HENRY HOCHGESANG</b>	4. DATE OF DEATH <b>Jan. 28 1962</b>
	5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>
	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15 1889</b>
	9. AGE (In years last birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
	11. BIRTHPLACE (County & State, or foreign country) <b>Oxford - New Jersey</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.G.</b>
	13. FATHER'S NAME <b>Charles Hochgesang</b>	14. MOTHER'S MAIDEN NAME <b>Mary Blessing</b>
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>NONE</b>
17. INFORMANT <b>Wife</b>	Address <b>536 Madison ST NW</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Pulmonary emphysema and chronic interstitial pulmonary fibrosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>congestive heart failure (recent)</b>	INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 1-28 1959</b> to <b>1-28 1962</b> that (I) (we) saw the deceased alive on <b>1-28 1962</b> and that death occurred at <b>10:38</b> from the causes and on the date stated above	22a. SIGNATURE <b>Edward W. Youngblood</b> M.D.	
22b. DATE PERFORMED <b>1-29-62</b>	22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. YOUNGBLOOD, M.D.</b>	
22d. ADDRESS <b>WASHINGTON CLINIC, WASHINGTON D.C.</b>	22e. REC'D BY REGISTRAR <b>1-29-62</b>	
22f. REGISTRAR'S SIGNATURE <b>W. E. Pumphrey</b>	22g. DATE <b>1-29-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-31-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>	24a. ADDRESS <b>843 Georgia Ave. Silver Spring, Md.</b>	
25a. REC'D BY REGISTRAR <b>1-29-62</b>	25b. REGISTRAR'S SIGNATURE <b>W. E. Pumphrey</b>	

**TO HOSPITAL, OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Patient may be examined by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00825

CERTIFICATE OF DEATH

00819

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres (Bethesda)</b> c. LENGTH OF STAY IN b. <b>57</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5904 Welborne Drive</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres (Bethesda)</b> d. STREET ADDRESS <b>5904 Welborne Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ernest</b> Middle <b>Lee</b> Last <b>Hoffman</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>20</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4/15/1883</b>
<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>William Hoffman</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary A. Hoffman</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>578-09-1024</b>		<b>17. INFORMANT</b> Address <b>5904 Welborne Dr. Woodacres, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 years</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>January, 1962</b> , to <b>Jan. 20, 1962</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Jan. 20, 1962</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Clifton R. Gruver</b>		<b>22b. DATE SIGNED</b> <b>1/20/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Clifton R. Gruver</b>		<b>22d. ADDRESS</b> <b>915 19th St. N.W. Wash. D.C.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>1/22/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>National Mem. Park</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Falls Church, Virginia</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S. H. Hines Co. - Washington, D. C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 22 '62</b> <b>DATE</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>	

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Maryland

Montgomery

Woodward (Baltimore)

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Edward

Holman

January 20

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Male

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Seaman

Baker

Virginia

U.S.A.

William Holman

Harry A. Holman

5201 Welbourne Dr.

276-09-1024 John Lee Holman - Woodward, Md.

no

William R. Thayer

Revised 1/22/63 National Hemisphere

Revised 1/22/63

The S. H. Rhodes Co. - Washington, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
CERTIFICATE OF DEATH											
00826											
00820											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>40 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> d. STREET ADDRESS <b>Rt.#1, Box 231</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Robert (N) Horton</b>						4. DATE OF DEATH <b>January 7 1962</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 8 1893</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Horton</b>						14. MOTHER'S MAIDEN NAME <b>Molly Mollie</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes WWI</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife Ethel Horton</b>		Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach with widespread metastases</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 November, 1961</b> to <b>7 January, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7 January, 1962</b> , and that death occurred <b>0045AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>A.T. Thorp Jr.</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>A.T. THORP LT MC USN</b>						22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-10-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>				23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gartners Funeral Home, 316E Diamond Ave., Gaithersburg, Md.</b>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			
DATE <b>JAN 9 '62</b>											



00828

NAVY

Beckman (Ronal)

NO 47

Calhoun

U.S. Naval Hospital

Box 241

Robert

(H)

Horton

January

Guantanamo

February 3, 1953

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Robert

Missouri

USA

Robert Horton

Molly Miller

yes

Wife Robert Horton

yes

X

January

52 November 01

January 02

A.T. THORP JR. MC 001

U.S. Naval Hospital, Bethesda, Md.

1-10-02

Robert

Calhoun, Md.

Calhoun, Virginia

Robert's Personal Home, 1100 Diamond Ave.,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00827  
00821

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> f. COUNTY <b>HOWARD</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b> d. STREET ADDRESS <b>LEISHEAR ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WALTER</b> <b>McBAIN</b>		First Middle Last <b>HOWES</b>		4. DATE OF DEATH Month Day Year <b>1 16 19 62</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>10/13/84</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>JAMES HOWES</b>		14. MOTHER'S MAIDEN NAME <b>WILLIE DWYER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>BRONCHOPNEUMONIA, BILATEAL</b> <b>491X</b> DUE TO <b>TRACHEOBRONCHITIS, ACUTE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>AORTIC ANEURYSM</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>022X</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Hour e.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
2Df. (City or town)		2Dg. (County)		2Dh. (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15 1963</b> to <b>Jan 16 1963</b> , that (I) (we) last saw the deceased alive on <b>Jan 16 1963</b> , and that death occurred at <b>12:35P</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M.D.</b>				22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-19-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>			
23d. LOCATION (City, town or county) <b>Sunshine, Md.</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 19 '62</b> DATE			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>							

1941

STATE OF TEXAS

1941

HOWARD

BARCLAY

HUNTER

LAUREL

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OLNEY

LEISHAN ROAD

HUNTER GENERAL HOSPITAL

HOUSE

HOLLY

WALTER

10/2/41

WHITE

NAME

BARCLAY

PAID

RECEIVED

WILLIE WYER

JAMES H. HARRIS

HOSPITAL RECORDS

HOPE

NO

12:52

ANDY SPRING, BARCLAY

A. J. HARRIS, D.

10/2/41

10/2/41

10/2/41

Lawsonville, Md.

Francis H. Barber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G305 1/22/62 iwk

00828

CERTIFICATE OF DEATH

Reg. Dist. No.

111822

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd</b>		c. LENGTH OF STAY IN 1b <b>61 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUSSELL SMITH HOYLE</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 15 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1900 Nov. 27-1908</b>	
9. AGE (In years lost birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Invalid--</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Smith Hoyle</b>				14. MOTHER'S MAIDEN NAME <b>Ella May Watkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		INFORMANT <b>Mrs Smith Hoyle, Boyds, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>AGENESIS IMPERFECTA CEREBRAL PALSY</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1950</b> , to <b>Jan 15 1962</b> that I last saw the deceased alive on <b>14 Jan 1962</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>P.O. Boyd, Md</b> DATE/SIGNED <b>1/15/62</b> ACTUAL SIGNATURE <b>John Fawcett</b> M.D. PHYSICIAN'S NAME (Type) <b>John Fawcett</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Boyd, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton</b>				ADDRESS <b>Barnesville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 19 '62</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	

CERTIFICATE OF DEATH

1928

Montgomery

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Montgomery

of age

years

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Nov. 27-1928

White

Male

Montgomery

Female

John W. Hester

John W. Hester

John W. Hester, Montgomery, Alabama

18

John W. Hester

John W. Hester

John W. Hester

John W. Hester

John W. Hester

Montgomery, Ala.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00829 CERTIFICATE OF DEATH 00823

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>14 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u> d. STREET ADDRESS <u>Box 201 Route 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL HUSBAND</u>		4. DATE OF DEATH <u>JANUARY 24 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 24 1962</u>
9. AGE (In years last birthday) <u>—</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES NOAH HUBBARD</u>	
14. MOTHER'S MAIDEN NAME <u>MARY LOU BOARMAN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>FATHER.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO <u>751.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Abletosis of lungs</u> (c) <u>Hydrocephalus &amp; Spina Bifida</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> , 19 <u>62</u> , to <u>1/24</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> , 19 <u>62</u> , and that death occurred at <u>3:17 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William F. Colleton</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>1-26-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	23d. LOCATION (City, town or county) (State) <u>BETHESDA, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA C. CARTER, ADMIN. - (P.F.D.)</u>		25a. REC'D BY REGISTRAR <u>JAN 30 '62</u>	
ADDRESS <u>SUBURBAN HOSP. BETHESDA, M.D.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be prepared by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00830  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>98 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Sumerville, G</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 4</b> d. STREET ADDRESS <b>49X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Emma Hughes</b>		4. DATE OF DEATH Month Day Year <b>January 29 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 28, 1902</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days <b>20 5</b>	IF UNDER 24 HRS. Hours Min. <b>20 5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Bridges</b>	
14. MOTHER'S MAIDEN NAME <b>Leobelle Payton</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopericardium</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Mycosis Fungoides</b> DUE TO (c) <b>Hydrothorax</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 23, 1961</b> , to <b>January 29, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 29, 1962</b> , and that death occurred <b>11:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul P. Carbone MD</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Paul P. Carbone, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/30/62</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State) <b>Sumerville Ga.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co., 1400 Chapin St. NW Wash. DC</b>		25a. REC'D BY REGISTRAR <b>JAN 31 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. K...</b>			



0520

History

Labhead

The Clinical Center, Bethesda, Md.

University

Room 4

May 1950

History

November 28, 1950

Example

Non-specific

None

Control

Very mild

Control

The Clinical Center

Responsible for the Clinical Center, Bethesda, Md.

Responsible for the Clinical Center

Responsible for the Clinical Center

Responsible for the Clinical Center

History

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History

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Control 22 January 22 1950

Paul F. Gardner, M.D.

Paul F. Gardner, M.D.

The Clinical Center, Bethesda, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00831

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00825

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Ohio</b> f. COUNTY <b>Hanoverton</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hanoverton</b> d. STREET ADDRESS <b>P.O. Box 93</b> g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HAROLD W HUK</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 13 19 62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1941</b>
9. AGE (In years last birthday) <b>20</b>		10. IF UNDER 1 YEAR Months Days <b>20 00</b>	
11. IF UNDER 24 HRS. Hours Min. <b>00 00</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Serviceman USN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baden, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ARTHUR Conrad HUK Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Emerick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NOX YES Oct 58 to date</b>		16. SOCIAL SECURITY NO. <b>290 34 6000</b>	
17. INFORMANT <b>WIFE: Mildred F. Huk, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal Skull Fracture</b>			
DUE TO (b) <b>Acute subdural hematoma</b>			
DUE TO (c) <b>Acute cerebral edema</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <b>Driver of car, which apparently missed curve and turned over.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00 p.m. Jan. 12, 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Intersection of Rt. 2 &amp; 17</b>		20f. (City or town) (County) (State) <b>Spotsylvania Co., Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHEAT</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1-13-62</b>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. LOCATION (City, town, or country) (State) <b>Hanoverton, Ohio</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hanoverton Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Hanoverton, Ohio</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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U. S. NAVAL HOSPITAL

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00832

## CERTIFICATE OF DEATH

Reg. Dist. No.

00826

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring (Rural)</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Silver Spring (Rural)</b>		d. STREET ADDRESS <b>607 Hollywood Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 Hollywood Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>FRANCIS</b> Last <b>HUSTON</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16th</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22nd, 1895</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Huston</b>		14. MOTHER'S MAIDEN NAME <b>Mary Keating</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Blanche M. King, 1902--14th St. S.E. Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> <b>3 3 4 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>10 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 2, 1961</b> , to <b>Jan. 16, 1962</b> , that I last saw the deceased alive on <b>Jan. 14, 1962</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington 11, D.C.</b> DATE SIGNED <b>1/16/62</b>			
ACTUAL SIGNATURE <b>Walter K. Angevine</b>		M.D. <b>6300-13<sup>th</sup> St. NW,</b>	
PHYSICIAN'S NAME (Type) <b>WALTER K. ANGEVINE</b>		<b>Washington 11, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/19/1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers, Inc. Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 19 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00833 CERTIFICATE OF DEATH 00827

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Basal</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN TB <u>11 days</u>		d. STREET ADDRESS <u>422 Oakwood St. SE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leroy H. Jacobi</u>		4. DATE OF DEATH Month Day Year <u>Jan 6 1962</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8 1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINE TYPE OPERATOR EVENING STAR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Charleston S.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>William Jacobi</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>578-09-8757</u>	
17. INFORMANT <u>Rosina Jacobi</u> Address <u>Wash 20 DC 422 Oakwood St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>Melanoma &amp; metastasis</u> 1970-9 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>11 Mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30, 1961</u> to <u>Jan 6, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 6, 1962</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. D. Bonifant</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>		22b. DATE SIGNED <u>Jan 6 1962</u>	
22d. ADDRESS <u>Fairly Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/9/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City, town or county) (State) <u>Bladensburg Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. 517 11th St SE DC</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 '62</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



CERTIFICATE OF DEATH

1963

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00834

00828

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (outside corporate limits, write RURAL and give nearest town) <u>12 ROCKVILLE</u> d. STREET ADDRESS <u>1 ROCKVILLE PIKE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHNSON, MARY</u> First Middle Last		4. DATE OF DEATH <u>1</u> <u>20</u> <u>1962</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/93</u> 9. Age (In years) <u>68</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (One kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>Asbury Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Adams</u>	
15. WAS DECEASED MEMBER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>		16. SOCIAL SECURITY NO. <u>218-30-369</u>	
17. INFORMANT <u>HARRY JOHNSON</u>		Address <u>Rockville, Md., 611 Douglas Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia, acute</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Sub-sternal Thyroid Hypertrophy; Anemia Severe</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-15</u> , 19 <u>62</u> to <u>1-20</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-19</u> , 19 <u>62</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Elvira E. Jackson</u> M.D.		22b. DATE SIGNED <u>1-20-62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>202 Martin Ln., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-23-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park -</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swander</u>		25a. REC'D BY REGISTRAR <u>MDAN, 25 '62</u> DATE	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

(M)

Montgomery

Bethesda

St. Albans Hospital

Tolson, Mary

General Manager

Secretary

Asst. Secretary

1

Harry Johnson

Louise Adams

Montgomery County

10/23/42

10/23/42

Rockville

Rockville P.O.

2 days

Montgomery

Montgomery



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and fill in pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00835  
00829  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>1401 21st Street, N.W. (?)</b>	
3. NAME OF DECEASED (Type or print) <b>Mary E. Johnson</b>		4. DATE OF DEATH <b>January 12 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/1867</b>
9. AGE (In years last birthday) <b>94</b>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>--- Vanderpoel</b>		14. MOTHER'S MAIDEN NAME <b>Unobtainable</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Miss Patricia M. Sinnott-New York, N.Y.</b>		Address <b>325 West 45th St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 428.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1962</b> to <b>Jan 12, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 10, 1962</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Eino Magi</b>		22b. DATE SIGNED <b>1-12-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>EINO MAGI</b>		22d. ADDRESS <b>918 Univ. Blvd. E, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/15/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

M

00832

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

NO

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00836

CERTIFICATE OF DEATH

Item 2 111m G307 2/13/62 ink

00830

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> <u>Newly arrived from the State of</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	c. LENGTH OF STAY IN 1b <u>ENTERED 12-2-61</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington / Silver Springs, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		d. STREET ADDRESS <u>3050 Bland Rd. NW</u> <u>800 Roeder Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>J.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-79</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>30 YRS. AGO</u> <u>Railway express</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Jones</u>		14. MOTHER'S MAIDEN NAME <u>SARAH F. Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Lillian Humphries</u>		Address <u>Spring, Md</u> <u>800 Roeder Rd. Silver</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertatic pneumonia and</u> <u>715X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Toxemia</u> DUE TO (c) <u>Decub. ulcers and malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Nov. 21, 1961</u> , to <u>Jan 15, 1962</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Jan 14, 1962</u> , and that death occurred at <u>2:05</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>R. Stephen Hu Bonting</u>		22b. DATE SIGNED <u>Jan 18, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Stephen Hu Bonting</u>		22d. ADDRESS <u>3000 Dene Pl, Mr Nash, 2, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-18-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JAN 19 62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>		25c. REGISTRAR'S SIGNATURE	

60230

CERTIFICATE OF DEATH

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be removed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>322 Broadwood Drive</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>322 Broadwood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>R.</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>24,</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 27, 1912</b>
9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b>		IF UNDER 24 HRS. Hours <b>2</b> Min. <b>4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Art Director</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C I A</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Nebraska</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Julius Jones =</b>	
14. MOTHER'S MAIDEN NAME <b>Grace A. Thompson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Wife</b> <b>Mrs. Jo B. Jones</b> Address <b>Same as Item #2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary thrombosis</b> 4-20-62 Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerotic heart disease</b> (c) <b>shock due to dehydration from vomiting</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>cirrhosis of liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 h</b> <b>? years</b> <b>24 h</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 24, 1962</b> to <b>Jan. 24, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 24, 1962</b> and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.		22b. DATE SIGNED <b>Jan. 25, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr.</b>		22d. ADDRESS <b>809 Viers Mill Rd. Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/29/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 1 '62</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hennes</b>	





00838

## CERTIFICATE OF DEATH

Reg. Dist. No.

00832

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>2 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8001 EASTERN AVE APT. 102</b>				d. STREET ADDRESS <b>8001 EASTERN AVE APT. 102</b>			
3. NAME OF DECEASED (Type or print) First <b>GUSTAVE</b> Middle <b>A.</b> Last <b>KAISER</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>3</b> Year <b>1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 18, 1889</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUILDER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>ISAAC T. KAISER</b>			
14. MOTHER'S MAIDEN NAME <b>ANNA</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>INFORMANT</b>				Address <b>MRS. FRANCES MARGOLIS 1444 Buck CR. Ford Rd N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4-20-00</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b> <b>8 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL THROMBOSIS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1951</b> to <b>JAN. 3</b> , 1962 that I last saw the deceased alive on <b>DEC. 30</b> , 1961, and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Saul Zuckerman</b> M.D. <b>5410 Connecticut Ave</b>				DATE SIGNED <b>1-3-62</b>			
PHYSICIAN'S NAME (Type) <b>SALL ZUCKERMAN, M.D.</b>				<b>Washington 15, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-5-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BETH SHOLOM CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HILLSIDE M.D.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY + SONS</b> ADDRESS <b>3501-14th St. NW</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 8 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 00833

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVERSPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>/SILVER SPRING Washington, D. C. 47X2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND NURSING HOME</b>		d. STREET ADDRESS <b>1336 Jonquil St. N.W. FAIRLAND NURSING HOME</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MOLLIE KATZ</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 2, 1962 19</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>1867</b>	9. AGE (In years last birthday) <b>94</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>000</b>	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>
13. FATHER'S NAME <b>ISAAC SANDLER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		INFORMANT Address <b>HARRY KATZ 1336 JONQUIL ST., N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive heart failure</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Cardiac hypertrophy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>20 yrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 31, 1961</b> to <b>Jan 2, 1962</b> that I last saw the deceased alive on <b>Jan. 2, 1962</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. John E. Virnstein</b>		DATE SIGNED <b>3311-16. 777. Wash. 10 DC</b>	
PHYSICIAN'S NAME (Type) <b>Dr. John E. Virnstein</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN. 4, 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OSHEV SHOLOM-TALMUD TORAH CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS 3501 14th St.</b>		24a. REC'D BY REGISTRAR <b>Jan 8 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00840

00834

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>7508 BenAvon Rd.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>N.</u> Last <u>Keating, Sr.</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>26</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12/24/03</u>
<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Director</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>A.I.D.</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Kansas</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>James Keating</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen Harrington</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>wife-Jean M. Keating same as above</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic insufficiency</u> DUE TO (b) <u>Massive Metastatic Carcinoma,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Primary site, undet</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Nov 59</u> to <u>Jan 26, 1962</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> <u>1962</u> , and that death occurred at <u>9:15</u> A.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Dr. Michel M. Healy</u>		<b>22b. DATE SIGNED</b> <u>1/26/62</u>	<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Michel M. Healy</u>
<b>22d. ADDRESS</b> <u>5523 Trent St., Chevy Chase, Md.</u>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>1-29-62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Montgomery County, Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u>		<b>24b. ADDRESS</b> <u>Bethesda, Md.</u>	<b>25a. REC'D BY REGISTRAR</b> <u>1 '62</u>
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur J. Harris</u>		<b>DATE</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

00841

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00835

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>2 Namassin Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Zalman</b> First <b>Abraham</b> Middle <b>Kekst</b> Last		4. DATE OF DEATH <b>January 3,</b> 19 <b>62</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1931</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	9. AGE (In years last birthday) <b>30</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Kekst</b>		14. MOTHER'S MAIDEN NAME <b>Anna Lewensohn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>006-30-3506</b>	
17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic pericarditis with massive pericardial effusion</b> DUE TO (b) <b>Gaucher's disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 3, 1962</b> to <b>January 3, 1962</b> that (I) (we) last saw the deceased alive on <b>January 3, 1962</b> , and that death occurred at <b>6:20PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Karl Engelman</b> M.D.		22b. DATE SIGNED <b>1/4/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>KARL ENGELMAN, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 4, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>FALLS CHURCH, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry B. Bear</b> ADDRESS <b>Alexandria, Va.</b>		25a. REC'D BY REGISTRAR <b>JAN 5 '62</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

00241

Montgomery

Bedford

I Day

Alexander

2 Newman Road

The Clinical Center, Bethesda, Md.

Calvin

Arthur

Robert

January 2

30

July 2, 1931

John

also

Attorney

Government

Representatives

Joseph Robert

Anna Lewandowski

The Medical Records

NOV-30-1938

The Clinical Center, Bethesda, Md.

Hemorrhagic pericarditis with massive pericardial

hemorrhagic disease

30 years

January 2

6:20 PM

January 2

1/1/32

x

The Clinical Center, National

Institute of Health, Bethesda, Md.

WALLS CHURCH

KLING DAVID CENTER

W.D. BROOKMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sund Hospital</u>		d. STREET ADDRESS <u>3360 CHILLUM RD.</u>	
3. NAME OF DECEASED (Type or print) <u>Tracey Anne Kelley, Baby Girl</u>		4. DATE OF DEATH <u>January 9 1962</u>	
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-62</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Richard Kelley</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA WYATT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>                    </u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HyperBILIRUBINEMIA</u> 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABO BLOOD INCOMPATABILITY</u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>29 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>                    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. (City or town) (County) (State) <u>                    </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>1-8-1962</u> to <u>1-9-1962</u> that (1) (we) last saw the deceased alive on <u>1-9-1962</u> and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Mary K. L. Sartwell, M.D.</u>		22b. DATE SIGNED <u>1-9-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Mark K. L. Sartwell, M. D.</u>		22d. ADDRESS <u>6811 Riggs Rd., Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-12-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		25a. REC'D BY REGISTRAR <u>                    </u>	
ADDRESS <u>3821-14th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>                    </u>	
DATE <u>1-15-62</u>		DATE <u>                    </u>	

2075191155

M

BARBARA WYATT

Barbara Wyatt  
1111 1st St. N.W.  
Washington, D.C. 20004

VS. A15ME  
5M 9/60

## MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>md</i> b. COUNTY <i>Montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burtonsville</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3020 Maple Hill Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lorenzo Charles Kidwell</i>		4. DATE OF DEATH First Middle Last <i>Jan 26 1962</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-15-82</i>
9. AGE (in years last birthday) <i>80</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Melvin Kidwell</i>		14. MOTHER'S MAIDEN NAME <i>Cathani Harrison</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-18-2170</i>	
17. INFORMANT <i>Melvin A. Kidwell (son)</i>		Address <i>Itum 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>History of previous heart disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		DATE SIGNED <i>1-26-62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-29-62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Burtonsville Union Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>Burtonsville Maryland</i>	
23. FUNERAL DIRECTOR <i>RQ Giska</i>		24a. REC'D BY REGISTRAR <i>JAN 29 '62</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>			

OR ATTENDING PHYSICIAN: The law requires that the death certificate be  
may be retained by the hospital or attending  
DIRECTOR: After this certificate

After this



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00844

00838

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 Baltimore Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u> d. STREET ADDRESS <u>300 Baltimore Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FOREST</u> Middle <u>KING</u> Last <u>KING</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>13</u> Year <u>19 62</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 31, 1893</u>		<b>9. AGE</b> (In years last birthday) <u>68</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months Days	Hours Min.																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>E. D. King</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrude Lawson</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Pearl E. King-Item # 2</u>		Address											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary thrombosis</u> DUE TO (c) <u>coronary arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>20</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.)													
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County)		(State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>1/11/1962</u> to <u>1/13/1962</u> ; that (I) (we) last saw the deceased alive on <u>1/11/1962</u> ; and that death occurred at <u>P.A.M.</u> from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <u>Stephen N. Jones</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>1/13/62</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stephen N. Jones</u>						<b>22d. ADDRESS</b> <u>809 Viers Mill Road, Rockville, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/15/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Rockville, Maryland</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler</u>						ADDRESS <u>1331 E. Montg. Ave.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 15 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>S. H. HARRIS</u>							

MEDICAL CERTIFICATION

TO HOS- death. Pa-  
 TO FUNER- director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 This certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then please remove carbon papers.

RECEIVED AT THE CENTRAL OFFICE OF DEATH

14

15

RECEIVED AT THE CENTRAL OFFICE OF DEATH

RECEIVED AT THE CENTRAL OFFICE OF DEATH

15

RECEIVED AT THE CENTRAL OFFICE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00845

00839

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS</b>		d. STREET ADDRESS <b>2737 CATHEDRAL AVE., N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY C KINNEY</b>		4. DATE OF DEATH Month Day Year <b>JAN 12 19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 19, 1877</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE. C. KATLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>A.G. NICHOLS, JR.</b>		725 15th ST., N.W. <b>WASHINGTON, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>20 yrs.</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1951</b> to <b>1/12</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>62</b> and that death occurred at <b>3:30</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Latimer, Jr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John W. Latimer, Jr.</b>		22d. ADDRESS <b>1728 Mass Ave N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation Jan 13-1962 Cedar Hill Cemetery, Suitland, P.H. Md.</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaudes, Sr. Wash, D.C.</b>		25. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

(M)

(1)

00845

OFFICE OF CLERK

DISTRICT OF COLUMBIA

MONTGOMERY COUNTY

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

NAME

NAME

NAME

WHITE

WHITE

WASHINGTON, D.C.

UNKNOWN

UNKNOWN

LOUISIANA, C. K. K. K.

UNKNOWN

WASHINGTON, D.C.

UNKNOWN

UNKNOWN

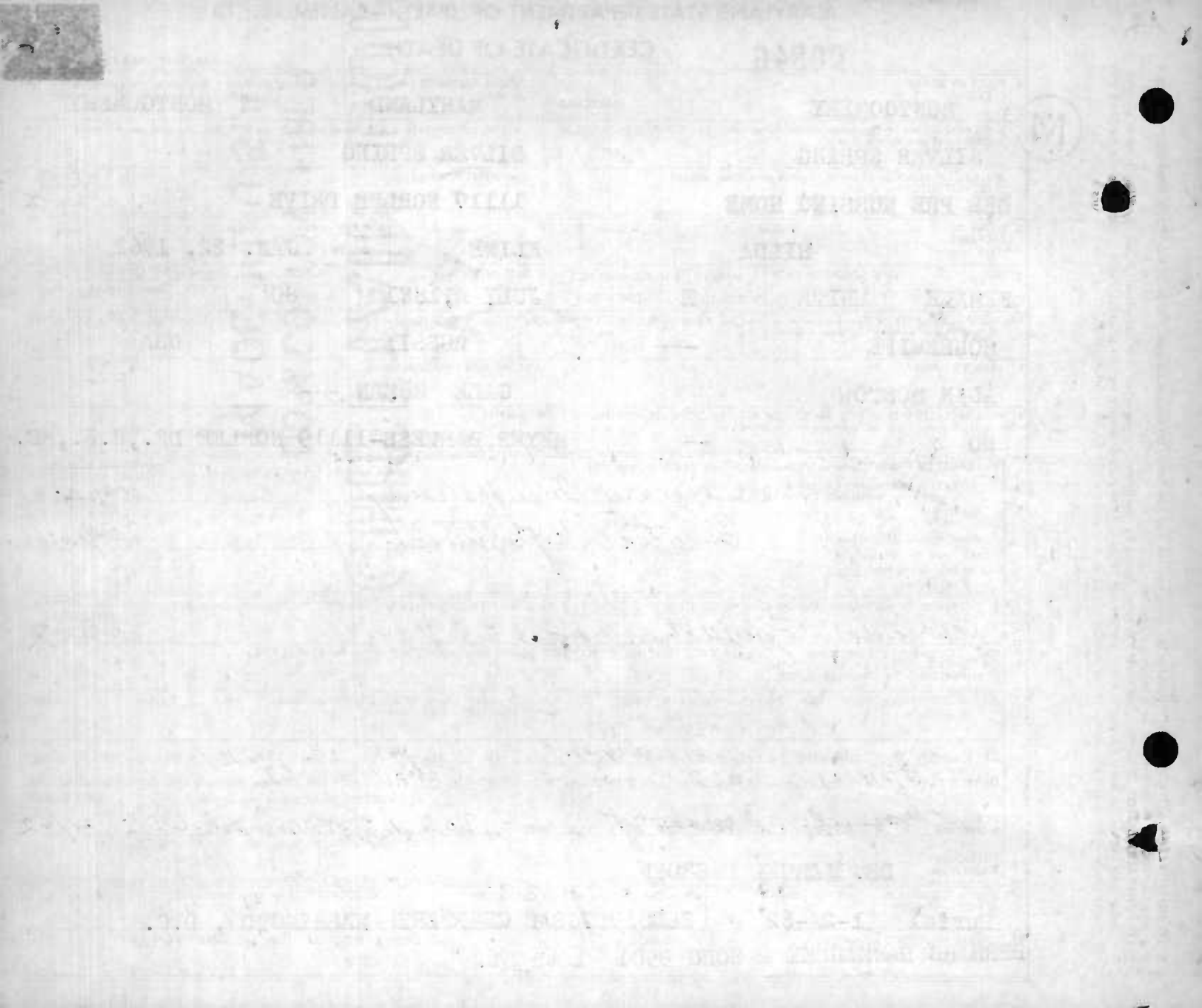
00846

## CERTIFICATE OF DEATH

Reg. Dist. No. 110840

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 39</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BEL PRE NURSING HOME</b>				d. STREET ADDRESS <b>11119 NORLEE DRIVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HILDA KLINE</b>				4. DATE OF DEATH Month Day Year <b>JAN. 22, 1962 19</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 4, 1881</b>		9. AGE (In years last birthday) <b>80 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALAN MOSTOW</b>				14. MOTHER'S MAIDEN NAME <b>GALE SUSAN ---</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT Address <b>MEYER BARWESS-11119 NORLEE DR., S.S., MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420 Coronary Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>25 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis part 25 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1945</b> , 19___, to <b>JAN. 22, 1962</b> that I lost saw the deceased alive on <b>JAN. 21, 1962</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel Dessoff</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. 1302-1850 NW Wash. D.C. 1/22/62</b>			
PHYSICIAN'S NAME (Type) <b>DR. SAMUEL DESSOFF</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-24-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ELESAVETGRAD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS</b>				ADDRESS <b>3501 14th St.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frame</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be filed with the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00847

00841

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1233 Simmons Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lucille</u> Middle <u>D.</u> Last <u>Koshnick</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>4</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4/15/88</u>	
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mich.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Koshnick</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Green</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW 1</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>cousin, G.L. Healey- 13103 Arctic Ave.,</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m.			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <u>Rockville, Md.</u>				<b>20g. (County)</b> <u>Montgomery</u>			
<b>20h. (State)</b> <u>Md.</u>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct. 1959</u> <b>to</b> <u>Jan. 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1-3-1962</u> <b>and that death occurred at</b> <u>10:30 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>W. G. Hall</u> M.D.				<b>22b. DATE SIGNED</b> <u>1-4-62</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. G. Hall</u>				<b>22d. ADDRESS</b> <u>615 W. MONTGOMERY AVE ROCKVILLE, MD</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/8/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Arlington, Virginia</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>JAN 9 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>	



10842

Montgomery

Baltimore

Shannon

Leah

Kenneth

Marie - White

Walter

Robert

Walter

John

USA

Joseph

Kenneth

Mary

Green

Yes

None

County, G.L. Healy - 19103 Arctic Ave.,  
Baltimore, Md.

G. Hall

Robert

19103

Arctic Avenue

Baltimore, Md.

Robert A. Emmert, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00848				Item 8 Film G306 2/6/62 iwk				00849			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY in 1b <b>127 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>1205 Prospect Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>WINSTON</b> Last <b>KRAFT</b>				4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1909</b> <b>1 January 1904</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. <b>53</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Plumber</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip H. Kraft</b>						14. MOTHER'S MAIDEN NAME <b>Anna S. Cardozo</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WW II &amp; Korean</b>				16. SOCIAL SECURITY NO.		17. INFORMANT (Wife) <b>Mrs. Lucille M. Kraft</b>		Address <b>same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASTROCYTOMA</b> <b>1939</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 23, 1961</b> to <b>January 27, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 27, 1962</b> and that death occurred at <b>9:36 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>C. W. Bramlett</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>28 January 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. W. Bramlett LCDR MC USN</b>						22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-31-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>				23d. LOCATION (City, town or county) <b>Arlington, Virginia</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mattingly</b>						ADDRESS <b>Washington, D.C.</b>		REC'D BY REGISTRAR <b>JAN 30 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frame</b>	

00242



U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

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U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00849

00843

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>Since Jan 17, 1962</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11708 Caplinger Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Kuykendall</u>		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Amos Adams</u>		14. MOTHER'S M maiden NAME <u>Susan Hollenback</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FRANK M. DUNCAN</u> Address <u>Son-in-law 11708 Caplinger Rd. S.S. Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Rt Lung</u> Conditions, if any, which gave rise to immediate cause (b) <u>491X</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Cardiovascular Disease</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17, 1962</u> to <u>Jan 27, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 26, 1962</u> , and that death occurred at <u>9:56 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen, M.D.</u>		22b. DATE SIGNED <u>Jan 27, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-29-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwell Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Mineral County W. Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JAN 31 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		25c. ADDRESS <u>Georgia Ave</u>	

1918

CERTIFICATE OF DEATH

1918

Home of Virginia

NOTE

Transcribed from original

Johnnie Lee Williams

Johnnie Lee Williams

Johnnie Lee Williams

Johnnie Lee Williams

Johnnie Lee Williams

Johnnie Lee Williams



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician may retain the original or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00850

111844

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		d. STREET ADDRESS <u>7130-8 St N.W. 47X3</u>	
3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>LACHMAN</u> Last <u></u>		4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Ring</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Gertrude Katz - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident - Cerebral arteriosclerosis and Arteriosclerotic hyperkinesis cardiovascular disease</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-29-61</u> <u>710 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1957</u> to <u>1-3</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-2</u> , 19 <u>62</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Jason Geiger, M.D.</u>		22b. DATE SIGNED <u>1-3-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>		22d. ADDRESS <u>1112 SPRING STREET SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-5-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 E. Taylor Pl</u>		25a. REC'D BY REGISTRAR <u>JAN 8 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

DEPARTMENT OF DEATH

1910



UNITED STATES DEPARTMENT OF DEATH

POST OFFICE

NOV 11 1910

CERTIFICATE OF DEATH

Reg. Dist. No.

00940

00851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6517 Millwood Road</u>		1. d. STREET ADDRESS <u>6517 Millwood Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>La Croix</u>		4. DATE OF DEATH Month Day Year <u>January 24 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-61</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR <u>18</u> Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jean Claude La Croix</u>		14. MOTHER'S MAIDEN NAME <u>Rosemary Mc Dermott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute interstitial pneumonitis, viral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute congestion, larynx and trachea, from</u> DUE TO (c) <u>Inhalation, stomach contents</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute hypoxia, manifested by, petechiae in thymus, brain and heart</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1-22</u> , 19 <u>62</u> , to <u>1-24</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>62</u> , and that death occurred at <u>2:10 P</u> M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>W. Fleet Luchita</u>	ADDRESS (Street, city or town, state) <u>5800 Reno Rd. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>William F. Lockett M.D.</u>	DATE SIGNED <u>3-22-62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/29/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Urbington Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Urbington Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Humphrey</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 27 '62</u>
ADDRESS <u>Bethesda Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Humphrey</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FILM #209- 3/29/68 - ORIGINAL CERTIFICATE  
UNDER ADOPTED NAME OF MELINDA VERMILYE.  
MB-







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after the death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Olney, Md.</b> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Brooke Grove Foundation</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda 45</b> d. STREET ADDRESS <b>9815 Singleton Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ElNora</b> Middle <b>Blythe</b> Last <b>Lamiman</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>5</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Salt Lake City, Utah</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Christian sen</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Christiansen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (e) <b>Branchopneumonia</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Cerebrovascular Accident</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>1 mo</b> <b>yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> , 19 <b>66</b> , to <b>1/2</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>61</b> , and that death occurred at <b>3:30 p.m.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Higdon</b>		22b. DATE SIGNED <b>1/2/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. Higdon</b>		22d. ADDRESS <b>Sandy Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1-6-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Zanesville, Ohio</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>JAN 5 '62</b>	
ADDRESS <b>Laytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

STATE OF OHIO

1923

(M)

no

Housewife

none

no

1-6-21

Francis A. Brown, Dayton, Ohio, Jan 2, 1923

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00854

02075

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown</b> <b>10X-2</b> d. STREET ADDRESS _____ a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy Rt. # 3</b>			c. LENGTH OF STAY IN 1b <b>2 months</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mt. Airy Rt. # 3</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Daniel Webster Lee-Sr.</b>			4. DATE OF DEATH Month Day Year <b>January 30, 1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-1880</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co. Maryland</b>	
13. FATHER'S NAME <b>William F. Lee</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
14. MOTHER'S MAIDEN NAME <b>Susan Ball</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Daniel W. Lee, Jr. Adamstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the rectum with generalized metastases</b> 154X <b>154</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 years - 10 years -</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (the hospital) attended the deceased from <b>February 10, 1959</b> to <b>January 30, 1962</b> that (I) (we) last saw the deceased alive on <b>January 16, 1962</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>James P. Kerr</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/30/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>		22d. ADDRESS <b>Damascus, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-2-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey and Son</b> ADDRESS <b>Frederick, Maryland</b>			25a. REC'D BY REGISTRAR <b>FEB 7 '62</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

08075

08075

Frederick

Frederick

Frederick

Adamsdown

2 months

10. May 18. 3

10. May 18. 4

x

20

20

January

Jan. 18.

Webster

Daniel

81

2-13-1883

X

White

Male

U.S.A.

Howard Co. Maryland

Living

Heated tower

Susan Bell

William F. Lee

Mr. Daniel W. Lee, Jr. Adamsdown, Maryland

None

No

XX

James P. Kent

Frederick, Maryland

U.S. Census Bureau

2-2-1883

Daniel

Robert A. Kelley and Son, Frederick, Maryland

TO HOSPITAL OR FUNERAL HOME: This certificate is to be filled out by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00855

00847

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 10.</u> d. STREET ADDRESS <u>1680 Irving Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edith Yates Lee</u>				<b>4. DATE OF DEATH</b> <u>January 13, 1962</u>			
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>December 8, 1887</u>	
<b>9. AGE</b> (In years last birthday) <u>74 yrs.</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired - Internal Revenue Service</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Jersey</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Harry Lee</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Kate Yates</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or <u>unknown</u> ) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>578-46-6457</u>			
<b>17. INFORMANT</b> <u>Hospital Record</u>				<b>Address</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Block - complete</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Disease</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 - days</u> <u>5 years.</u> <u>2 years.</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>Jan 10, 1962</u> <b>to</b> <u>Jan 13, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 12, 1962</u> <b>and that death occurred at</b> <u>3:15 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Robert A. Hare</u> <u>assoc. with Dr. Geo. Henry his regular home physician</u>				<b>22b. DATE SIGNED</b> <u>1/13/62</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert A. Hare</u> <u>M.D.</u>				<b>22d. ADDRESS</b> <u>1600 Carroll Ave., T. Park, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE THEREOF</b> <u>1/15/1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Methodist Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Haleysville, New Jersey</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co. - 2901 14th St., N.W.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>JAN 15 '62</u>			
<b>ADDRESS</b> <u>Washington 9, D.C.</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>			

(M)

(1)

Atherosclerosis  
Coronary Disease  
Heart Block - complete

Robert A. Hare  
M.D.  
1000 1st Avenue  
New York, N.Y.

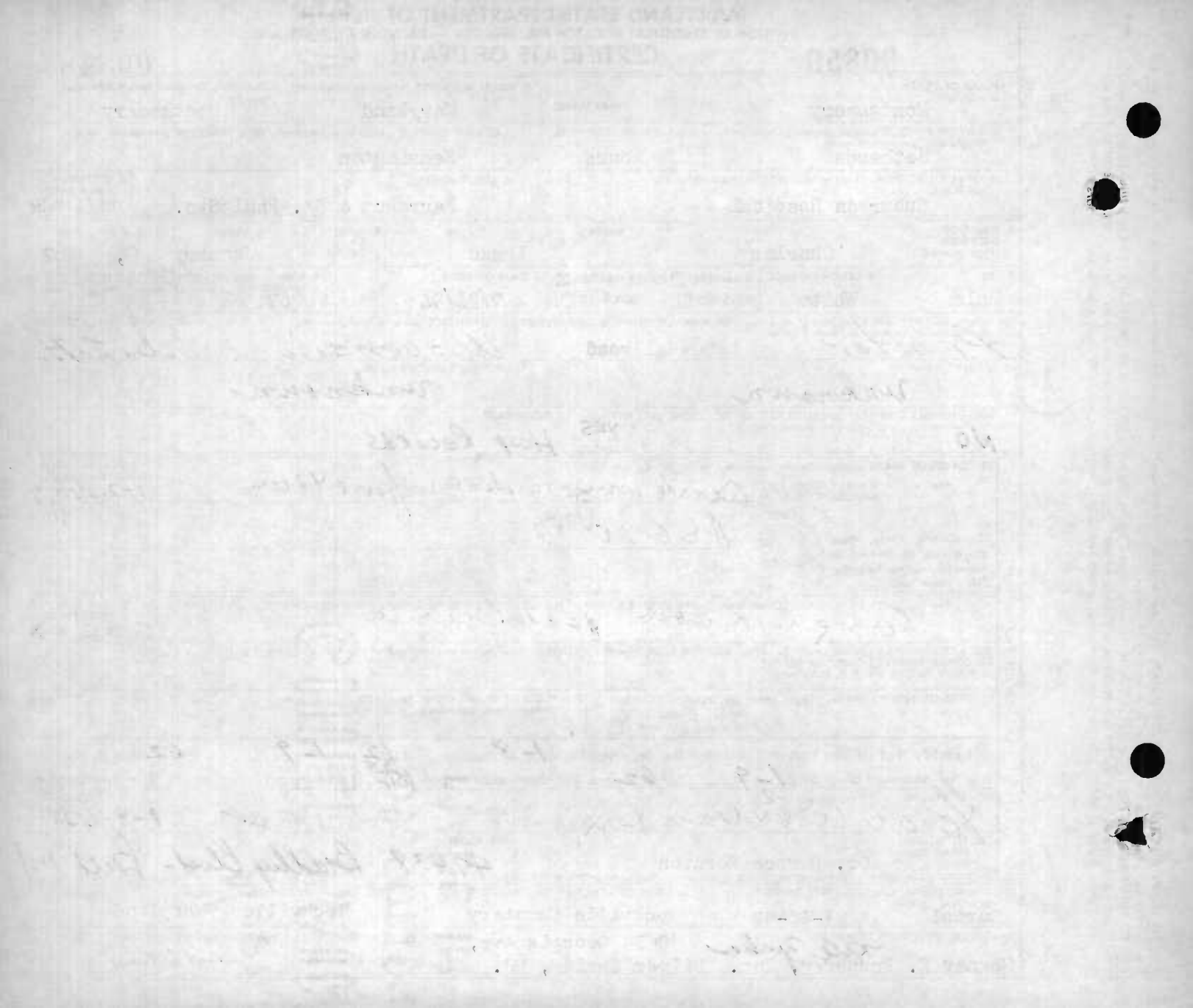


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
00856  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
00848

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>22 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. STREET ADDRESS <b>Farragut &amp; St. Paul Sts.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Lemke</b> Last <b>Lemke</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/31/94</b>
9. AGE (In years lost birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months <b>67</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>YES</b>	
17. INFORMANT <b>Hosp Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> (c) <b>ASCVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>congestive failure</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-8</b> <b>1962</b> to <b>1-9</b> <b>1962</b> that (I) (we) lost saw the deceased alive on <b>1-9</b> <b>1962</b> and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Horace W. Bernton</b>		22b. DATE <b>1-9-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Horace Bernton</b>		22d. ADDRESS <b>47438 Bradley Blvd - Beth. Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-16-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 18 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Warner E. Pumphrey</b>		25c. ADDRESS <b>8454 Georgia Ave, Silver Spring, Md.</b>	



TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00857

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>2 wks.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Shipman</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83x-3</b> d. STREET ADDRESS <b>—</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Grover</b> Middle <b>Carlton</b> Last <b>Ligon</b>		<b>4. DATE OF DEATH</b> Month <b>1</b> Day <b>10</b> Year <b>1962</b>		<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10/8/1984</b>		<b>9. AGE</b> (In years last birthday) <b>77</b>		<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>10</b>		<b>IF UNDER 24 HRS.</b> Hours <b>19</b> Min. <b>62</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>(CARPENTER,) RETIRED</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CONTRACTOR</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Va.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>William Daniel Ligon</b>								<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia Conner</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>—</b>				<b>17. INFORMANT</b> <b>Office Records</b>				<b>Address</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease and Pulmonary Fibrosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) } (c) }												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Arteriosclerotic Aneurysm, Aorta - Leriche Syndrome</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>22a. TIME OF INJURY</b> Hour <b>—</b> a.m. <b>—</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Shipman</b>		<b>(County)</b> <b>Nelson</b>		<b>(State)</b> <b>Virginia</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from 11/9/62 to 11/10/62, that (I) (we) last saw the deceased alive on 11/9/62, and that death occurred on 11/10/62, from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <b>C. H. Ligon</b>								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/>		<b>MED. DIRECTOR</b> <input type="checkbox"/>		<b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>11/10/62</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>C. H. Ligon</b>								<b>22d. ADDRESS</b> <b>Olney, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>				<b>23b. DATE THEREOF</b> <b>1-13-62</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Family Burial Grounds</b>				<b>23d. LOCATION</b> (City, town or county) <b>Shipman, Nelson, Virginia</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis H. Barber</b>								<b>ADDRESS</b> <b>Laytonsville, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>JAN 15 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>			

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(M)

1952

Montgomery

Owner

Shipman

Montgomery General Hospital

Glover

Carlson

Ligon

K.W.

10/8/52

Contractor

(Contractor) Retired

W.B.

John Connor

William Daniel Ligon

Office Records

10

*Handwritten notes:*  
1. Ligon, William Daniel  
2. Ligon, John  
3. Ligon, William Daniel  
4. Ligon, John  
5. Ligon, William Daniel  
6. Ligon, John  
7. Ligon, William Daniel  
8. Ligon, John  
9. Ligon, William Daniel  
10. Ligon, John

W.B. Ligon

John Connor

1-13-52

Montgomery

Thomas M. Ligon, KKK

Davidson, J.

W.B. Ligon

John Connor

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00858											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>12211 MIDDLE ROAD</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>12211 MIDDLE ROAD</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTG.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 SILVER SPRING</b> d. STREET ADDRESS <b>12211 MIDDLE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MYER</b>			First <b>MYER</b> Middle <b>LIPKIN</b> Last <b>LIPKIN</b>			4. DATE OF DEATH <b>JAN. 1 1962</b>			Month <b>JAN.</b> Day <b>1</b> Year <b>1962</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN-11-1898</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING SUPPLY</b>				11. BIRTHPLACE (County & State, or foreign country) <b>DC.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS LIPKIN (Dec.)</b>						14. MOTHER'S MAIDEN NAME <b>RACHEL (Dec.)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>579-03-6078</b>				17. INFORMANT <b>ANNIE D. LIPKIN</b> Address <b>(same as 20a)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163x Human base from lung</b> DUE TO (b) <b>Metastatic lesions of lungs</b> DUE TO (c) <b>Carcinoma of lung - left</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>1 yr</b> <b>3 yrs.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> to <b>1-11</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>61</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Francis F. Richardson</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>1/1/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>F. X. RICHARDSON</b>						22d. ADDRESS <b>1141 Viers Mill Rd. Wheaton MD.</b>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/3/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL Cem.</b>				23d. LOCATION (City, town or county) (State) <b>SUITLAND, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goodley Funeral Home</b> ADDRESS <b>4217 9th Ave</b>						25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		

REPORT OF DEATH

10000

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00859

00851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Point (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		d. STREET ADDRESS <u>08X2</u>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First <u>Janet</u> Middle <u>WLOYD</u> Last		4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bryantown, Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Austin Miles Dyer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Queen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Cecelia L. Miller-Daughter</u>		Address <u>9411 Warner St., Silver Spring Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ESSENTIAL HYPERTENSION</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> , 19 <u>61</u> , to <u>1-22</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1-22</u> , 19 <u>62</u> , and that death occurred at <u>10:40</u> p.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>Newton Fowden</u>		22b. DATE SIGNED <u>1-22-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur S. Hanna</u>		22d. ADDRESS <u>5206 Norway Dr. Chevy Chase, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-24-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		23d. LOCATION (City, town or county) (State) <u>Isslewood Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u>		25. REC'D BY REGISTRAR DATE <u>JAN 26 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

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TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. It may be obtained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00860

00852

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Vermont</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Peru</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>82X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>(n)</b> Last <b>MacFarlane</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 13, 1897</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>X</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Boston, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James McKean</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>HUS: Scott B. MacFarlane, Same as #2</b>	
17. INFORMANT <b>HUS: Scott B. MacFarlane, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Metastatic Carcinoma of the ovary</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 24,</b> 19 <b>61</b> , to <b>Jan. 5</b> , 19 <b>62</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 5,</b> 19 <b>62</b> , and that death occurred at <b>5:45AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joel S. Goodwin</b> M.D.		22b. DATE SIGNED <b>January 5, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOEL S. GOODWIN LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>1-5-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

00220

Montgomery

Booth (Muriel)

U. S. Naval Hospital

June

Canadian

Female

Roussville

James Watson

No

U. S. Naval Hospital, June 1945

Unknown

Boston, Mass.

USA

December 13, 1907

Marriage

January 2, 1945

1935 date

Birth

Vermont

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00853

00861

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> <span style="float: right;">c. LENGTH OF STAY IN 1b 15 min.</span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> <span style="float: right;">83x-3</span> d. STREET ADDRESS <b>1736 Arlington Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Joseph Thomas Mackassay</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>Jan. 25 19 62</b> Month Day Year				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Aug. 31, 1887</b>		<b>9. AGE</b> (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Wisconsin</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				
<b>13. FATHER'S NAME</b> <b>Thomas Mackassay</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Honara Donahue</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Unknown Unknown</b>			<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>				
<b>17. INFORMANT</b> <b>S. Daugh: Miss Margaret Vincent, Same as #2</b>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dessecting aneurysm of the descending aorta</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> Hour a.m. p.m. <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 25, 1962</b> , to <b>January 25 19 62</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Januray 25 19 62</b> , and that death occurred at <b>8:10PM</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>W. F. Warrender</i> <b>M.D.</b>			<b>22b. DATE SIGNED</b> <b>Jan. 26, 1962</b>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>W. F. WARRENDER LT MC USN</b>			<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1-29-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington, Virginia</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Douglas W. Johnson</i> <b>ADDRESS</b> <b>Rinaldi Funeral Home, 816 "H" St., NE, Wash., D.C.</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 30 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Thomas</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



(1010) 00000000

S. Knight; Mrs Margaret Villiers;

**THE UNIVERSITY OF CHICAGO**

[illegible]



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00862

00854

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN b <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON GROVE</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE V. BEALL MAGRUOER</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-6-92</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>69</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES VERON BEALL</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE BOLTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Generalized advanced arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1961</b> to <b>Jan 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 15 1962</b> and that death occurred at <b>9:45A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. D. Bonifant</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M.D.</b>		22d. ADDRESS <b>SANJOY SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>1-14-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Rockville Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Grover B. Garton</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
ADDRESS <b>Fairfax, Virginia</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

M

1

MONTGOMERY

CLNEY

MONTGOMERY GENERAL HOSPITAL

PEETIE

V. BEAL

HARRIS

PEETIE

W

4-6-92

92

ROBERTS

MARYLAND

JAMES WERNER BEAL

MARY JANE BEAL

HOSPITAL RECORDS

MONTGOMERY

MARYLAND

WASHINGTON DRIVE

11 DAYS

10

4.2.1

SANDY SPRING, MARYLAND

A. G. ROBERTS, M.D.

11-2-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ashton</u> c. LENGTH OF STAY IN 1b <u>Since 1948</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Allen Acres</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u> d. STREET ADDRESS <u>Allen Acres</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Grace</u> Middle <u>W.</u> Last <u>Manchester</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>26</u> Year <u>19 62</u>											
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 5, 1874</u>		<b>9. AGE</b> (In years last birthday) <u>87 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Willis Leonard Wheeler</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lillian Funk</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Mrs. A.I. Smith Allen Acres Ashton, Maryland</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture abdominal aneurysm, aortic</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 hr</u> <u>20 yrs</u> <u>20 yrs</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 26, 1962</u> <b>to</b> <u>Jan 26, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 26, 1962</u> <b>and that death occurred at</b> <u>7:30 P.M.</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>A.D. B. ON IF ANT</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>A.D. B. ON IF ANT</u>						<b>22d. ADDRESS</b> <u>Severly Spry, m.d.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>1-29-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GREENWOOD CEMETERY</u>				<b>23d. LOCATION</b> (City, town or county) <u>BROOKLYN</u> <b>(State)</b> <u>NEW YORK</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WARNER E Pumphrey, Inc</u> <b>ADDRESS</b> <u>8434 GEORGIA AVE SILVER SPRING</u> <b>REC'D BY REGISTRAR</b> <u>JAN 31 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>															

CERTIFICATE OF DEATH

00863



Attest: I, J. L. Smith, Clerk of the Board of Health, do hereby certify that the foregoing is a true and correct copy of the original record on file in the office of the Board of Health, City of New York, on the 1st day of January, 1910.

100

NEW YORK

1910

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Mont. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>13 days</i>		d. STREET ADDRESS <i>114511 - Colesville Rd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Mary Lay</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>30</i> Year <i>1962</i>	
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/12/1917</i>	
9. AGE (In years last birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR: Months <i>6</i> Days <i>1</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PRACTICAL NURSE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>UNKNOWN</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Staunton Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>MRS. HERBERT L. Reynolds</i>		Address <i>75 E. WAYNE AVE SILVER SPRING</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Arteriosclerotic Heart Disease</i> (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>1/17</i> , 19 <i>62</i> to <i>1/30</i> , 19 <i>62</i> ; that (1) (we) last saw the deceased alive on <i>1/30</i> , 19 <i>62</i> , and that death occurred at <i>7:35</i> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>H. C. Magarini</i>		22b. DATE SIGNED <i>1/31/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. C. Magarini</i>		22d. ADDRESS <i>Richmill Med Center, Potomac</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>2-1-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Prince George Maryland</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Zisk</i>		25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc.</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Haines</i>		25c. ADDRESS <i>8430 Georgia Ave. Silver Spring, Md.</i>	
25d. DATE <i>FEB 2 '62</i>		25e. SIGNATURE	



✓



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00865

00857

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>McLean</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4311 Woodly Road</b> d. STREET ADDRESS <b>4311 Woodly Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ethel Waller Manship</b>		4. DATE OF DEATH Month Day Year <b>January 24 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1887</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>74</b>	11. IF UNDER 24 HRS. Hours Min. <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Thomas G. Waller</b>		14. MOTHER'S MAIDEN NAME <b>Syriena O. Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>DAUGHTER: Mrs. Muriel E. Foote, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Chr. Myelomonocytic Leukemia (leukemia)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>22 January 1962</b> to <b>24 January 1962</b> that (X) (we) last saw the deceased alive on <b>24 January 1962</b> , and that death occurred <b>9:53 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W F Warrender</b> M.D.		22b. DATE SIGNED <b>January 24, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. F. WARRENDER LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-25-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOSEPH GAWLERS FUNERAL HOME, WASH., D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 26 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

(M)

00000

Virginia

Massachusetts

Bill Woolly Road

January 1951

Aug. 9, 1951

USA

New York

Stephen D. Johnson

Thomas G. Walker

Unknown; Mrs. Harold E. Foote, Rome, N.Y.

Unknown

No

*Handwritten notes:*  
Financial Institution  
Investment for the future  
(A/C)

25 January 1951

25 January 1951

25 January 1951

U. S. Naval Hospital, Bethesda, Md.

W. F. WARDENBERG ET AL

Washington, Maryland

United States

1-25-51

Continued

JOSEPH DANIEL WARDENBERG, WARD, D.C.

TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00866

Item 23b, Film G305 1/11/62 jwk

00858

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>44 Bethesda</b>	
c. LENGTH OF STAY IN 1b <b>417 days</b>		d. STREET ADDRESS <b>14522 Gretna St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ava Mae Markman</b>		4. DATE OF DEATH Month Day Year <b>January 5 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Causasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 16, 1915</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months Days <b>46</b>	
IF UNDER 24 HRS. Hours Min. <b>46</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USN</b>		13. FATHER'S NAME <b>Elmond Tart</b>	
14. MOTHER'S MAIDEN NAME <b>Norma Betts</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Husband: Solomon Markman</b>		17. INFORMANT Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Carcinoma of the breast</b> DUE TO <b>with widespread metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>approx 2 1/2 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>170X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx 2 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>November 14, 1960 to January 5, 1962</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 14, 1960</b> to <b>January 5, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 5, 1962</b> , and that death occurred at <b>5:50 PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>B Barclay Shepherd</b> M.D. 22b. DATE SIGNED <b>January 9, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>B.M. SHEPPARD LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/9/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>CHEVY CHASE FUNERAL HOME, CHEVY CHASE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			



10867

Maryland

Maryland

Baltimore

Baltimore (Harris)

17 days

1922 October 20

U.S. Naval Hospital, Baltimore, Maryland

Watkins

Mrs

Age

January

January 10, 1922

Trans. Commission

USA

North Carolina

Homestead

Home Depot

Home Depot

Address: Baltimore, Maryland

to

*Copy of the report with which...*

November 14, 1922

January 2, 1923

*Enclosed*

R.M. SHIFFORD LT MC USA

U. S. Naval Hospital, Baltimore, Md.

ARLINGTON HOSPITAL

ARLINGTON HOSPITAL

CHEVY CHASE TOWNHALL HOME, CHEVY CHASE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00867

859

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bel Pre Nursing &amp; Convalescent Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>2800 Quebec Street N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>JULIE M. MAYER</b>		4. DATE OF DEATH Month Day Year <b>January 6 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 17, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	9. AGE (In years last birthday) <b>84</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S MAIDEN NAME <b>Ida Benkheimer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Philip Goldstein, Atty. Woodward Bldg., D.C.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> 422.1 } DUE TO (b) <b>Effemities of Old Age</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) <b>Arterio-sclerotic Cardio-Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> , 19 <b>60</b> , to <b>1/6</b> , 19 <b>62</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>11/6/62</b> , 19 <b>62</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Samuel Diener</b> M.D. 22b. DATE SIGNED <b>1/6/62</b> 22c. PHYSICIAN'S NAME (Type) <b>SAMUEL DIENER</b> 22d. ADDRESS <b>4201 Mass. Ave., N.W., Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Jan. 8, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 8 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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TO

FROM

SUBJECT

DATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00868

Item 23a & b, Film 0305 1/11/62 - iwk

00860

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>4 days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Vermont</b>		b. COUNTY <b>Huntington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. STREET ADDRESS <b>Wild Acres</b>		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Aida MacLean Mayo</b>		4. DATE OF DEATH Month Day Year <b>January 7 1962</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 7 1875</b>		9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13. FATHER'S NAME <b>Charles C. MacLean</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Manderson</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Husband, Chester F. Mayo Same as #2</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420-0 DUE TO (b) <b>Coronary Artery Thrombosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>4 January</b> ....., 19 <b>62</b> to <b>7 January</b> ....., 19 <b>62</b> ., that (X) (we) last saw the deceased alive on <b>7 January</b> .....19 <b>62</b> ., and that death occurred <b>125AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>M. W. VOSS</b>		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>M. W. VOSS LCDR MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Removal</b>		23b. DATE THEREOF <b>1/11/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview</b>		23d. LOCATION (City, town or county) (State) <b>Burlington, Vermont</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. BIRCH SONS Funeral Home</b>		24b. ADDRESS <b>3034 "M" Street, Georgetown</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					



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UNITED STATES OF AMERICA

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RECEIVED (HALL)

1 day

RECEIVED

U.S. Naval Hospital, Bethesda, Md.

Will Aries

Alvin Maclean

May

January 7

December 7 1945

RECEIVED

RECEIVED

Pennsylvania

Charles C. Maclean

RECEIVED

RECEIVED, Chester May 22 45

*Handwritten notes:*  
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Intelligence

January 65

January 65

*Handwritten signature:* M. V. Voss

M. V. VOSS FOR MC NEH

U. S. Naval Hospital, Bethesda, Md.

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Joseph E. Birch

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00869					00861				
Item 2 File G307 2/14/62 iwk									
1. PLACE OF DEATH e. COUNTY <u>Montg</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>				
c. LENGTH OF STAY IN 1b <u>18 Mo</u>					d. STREET ADDRESS <u>1228 I Street, N.W.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rest Haven. Rest Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Minnie</u>					4. DATE OF DEATH Last <u>Mcatee</u> Month <u>Jan</u> Day <u>19</u> Year <u>1962</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Oct 29-1873</u>				
9. AGE (In years last birthday) <u>88</u> yrs.					10. IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U S Sect. &amp; School Teacher</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co. Md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					13. FATHER'S NAME <u>William Mcatee</u>				
14. MOTHER'S MARDEN NAME <u>Virginia Purdum</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				
16. SOCIAL SECURITY NO. <u>422-2</u>					17. INFORMANT <u>Lvelyn Selby. 211 Cedar Ave. Gaithersburg</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Arteriosclerotic Heart Disease</u> 422-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <u>Chronic Myocarditis</u> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>62</u> to <u>1/19</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/19</u> , 19 <u>62</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Luciano L. Leal M.D.</u> M.D.									
22b. DATE SIGNED <u>1/19/62</u>									
22c. PHYSICIAN'S NAME (Type) <u>Luciano L. Leal M.D.</u>									
22d. ADDRESS <u>Gaithersburg, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>1-22-62</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown</u>									
23d. LOCATION (City, town or county) (State) <u>Darnestown Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner/ Gaithersburg, Md.</u>									
25e. REC'D BY REGISTRAR <u>JAN 23 '62</u>									
25b. REGISTRAR'S SIGNATURE <u>Ernest C. Gartner</u>									



ALBERT G. GARTNER, BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00862

00870

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS <u>16519 Old Farm La.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helena Evangeline McGough</u>				4. DATE OF DEATH Month Day Year <u>Jan 19 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Melrose Mass.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Alexander Muse</u>				14. MOTHER'S MAIDEN NAME <u>Anne Muse Jacquard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Ferullo 6519 Old Farm La.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1937</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1961</u> to <u>Jan 1962</u> that (I) (we) last saw the deceased alive on <u>15 Jan 1962</u> and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Herman C. Maganzini</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u>				22d. ADDRESS <u>6519 Old Farm La. Rockville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 1/19/62</u>		23b. DATE THEREOF _____		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cemetery</u>		23d. LOCATION (City, town, or county) <u>Stoneham, Massachusetts</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>JAN 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1907 Old Town

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00871

00863

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash. San. &amp; Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>1658-2</b> d. STREET ADDRESS <b>2307 Rittenhouse St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rosemary Helen McIntosh</b> First Middle Last 4. DATE OF DEATH <b>1-4-1962</b> Month Day Year		5. SEX <b>fe</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>5-31-25</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <b>36</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b> 13. FATHER'S NAME <b>James E. Dawn Jr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b> 14. MOTHER'S MAIDEN NAME <b>Lois Cecil Va.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <b>578-22-0960</b> 17. INFORMANT <b>Wash. San &amp; Hosp. Records. T. Pk. md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>CARCINOMA OF LUNG</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>3-4 month</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 20</b> , 19 <b>61</b> , to <b>1/4</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>1/3</b> , 19 <b>62</b> , and that death occurred at <b>8:35</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>7105 - Ryja Rd.</b> 22b. DATE SIGNED <b>1/4/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>1/8/1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>oakwood</b> 23d. LOCATION (City, town or county) (State) <b>Falls Church, Va</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Saffell Funeral Home</b> ADDRESS <b>475 H ST. N.W.</b> 25a. REC'D BY REGISTRAR <b>JAN 8 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	



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RECEIVED OF DEPT. OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00872

Items 3 & 5 fill in G507 2/15/62 iwk

CERTIFICATE OF DEATH

111864

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>adelphi</u> d. STREET ADDRESS <u>10525 Agemont Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLIE MAY MCLEAN</u>		<b>DATE OF DEATH</b> Month <u>Jan.</u> Day <u>30</u> Year <u>1962</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-3-88</u>
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Nswf</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>W. Va. Charleston</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>		<b>13. FATHER'S NAME</b> <u>Charlie Blount</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen Estep</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>	
<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>PT chart</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>  </u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 Hours</u> <u>8 Years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).</b> <u>Rheumatic heart disease &amp; mitral stenosis</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>1956</u> , <b>19</b> <u>1/30</u> , <b>to</b> <u>1/30</u> , <b>1962</b> , that (I) (we) last saw the deceased alive on <u>1/30</u> , <b>1962</b> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Hugh W. Frey</u>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b>
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>HUGH W. Frey</u>		<b>22d. ADDRESS</b> <u>1105 - Riggs Road</u> <u>Lewisdale, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>Feb. 2/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Va</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Halley's Funeral Home</u>		<b>ADDRESS</b> <u>Mt. Rainier</u> <u>Inc.</u> <u>md</u>	<b>25a. REC'D BY REGISTRAR</b> <u>Arthur L. House</u>
<b>DATE</b> <u>FEB 5 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician. Page 2 may be completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00873  
00865

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY in lb <b>22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>4911 Hampdon Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Catherine</b> <b>McNally</b>		4. DATE OF DEATH <b>January 25</b> <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1889</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lawrence Hines</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Embrey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Son: Lawrence Pugh, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of myocardium</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>coronary artery occlusion</b> (c) <b>Atherosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Aortic stenosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 3, 1962</b> , to <b>Jan. 25, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 25, 1962</b> , and that death occurred <b>6:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John W Brackett Jr</b> M.D.		22b. DATE SIGNED <b>Jan. 26, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN W. BRACKETT JR. LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-30-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>JAN 30 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

(M)

00822

Monetary

Monetary

Washington (Hill)

22 days

22 days

U. S. Naval Hospital

U. S. Naval Hospital

Operating

Operating

Operating

Operating

Female

15

Monetary

Monetary

Washington State

Washington State

11

Unknown

Unknown

10

Jan. 25

Jan. 25

25

Jan. 25

John W. Brannon, Jr., U. S. Naval Hospital, Bethesda, Md.

John W. Brannon, Jr., U. S. Naval Hospital, Bethesda, Md.

Robert A. Brannon, Jr., U. S. Naval Hospital, Bethesda, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
00874																			
00866																			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Elkton</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Route #2, Box 109</b> d. STREET ADDRESS <b>83x-3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>Hamilton Irvin Meadows</b>					4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1962</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 December 1911</b>		9. AGE (In years last birthday) <b>50 years</b>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>													
13. FATHER'S NAME <b>Irving Meadows</b>					14. MOTHER'S MAIDEN NAME <b>Edith Peyton</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes 1939 to 1945</b>					16. SOCIAL SECURITY NO. <b>Wife Goldie Meadows</b>					17. INFORMANT <b>Same as #2d</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRAUMATIC AORTIC INSUFFICIENCY</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH 6 DAYS</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Harrisburg, Virginia</b>		20g. (County) <b>Harrisburg, Virginia</b>		20h. (State) <b>Harrisburg, Virginia</b>									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 December, 1961</b> to <b>6 January, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 January, 1962</b> , and that death occurred at <b>217 PM</b> from the causes and on the date stated above.										22a. SIGNATURE <b>C. W. BRAMLETT</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>C. W. BRAMLETT LCDR MC USN</b>					22b. DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/8/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East Lawn Memorial Garden</b>		23d. LOCATION (City, town or county) <b>Harrisburg, Virginia</b>		23e. (State) <b>Harrisburg, Virginia</b>		23f. (County) <b>Harrisburg, Virginia</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. PUMPHREY</b> Furneral Home 7557 Wisconsin Ave. JAN 9 '62										25a. REC'D BY REGISTRAR <b>Jan 9 '62</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				



00874

Virginia

Continuity

Deborah (Hunt)

9 days

Wilson

U.S. Naval Hospital, Bethesda, Maryland, Room 45, Box 109

Hamilton

Ivin

Meadows

January

Male

Unmarried

11 December 1911

30 years

Civil Service

U.S. Government

Virginia

USA

Living Meadows

Edith Peyton

1939 to 1941

With Debbie Meadows

Room 45, Box 109

X

29 December 01

8 January 02

8 January 02

SAVEN

G. W. HANNAH JR. NO. 100

U.S. Naval Hospital, Bethesda, Md.

First Name: Hannah, Virginia

Address: 1000

Address: 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Montgomery, Kensington MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>11601 High View Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Pauline Melcher</b> First <b>CARRIE</b> Middle <b>MELCHER</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1869</b>
9. AGE (In years, months, days, hours, minutes) <b>92</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Philip Melcher</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Rutter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>PAULINE C. HINCHMAN</b> Address <b>SAME AS #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>570.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mesenteriothrombosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture (intracapsular) of left hip</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 5</b> 19 <b>62</b> to <b>Jan 8</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Jan 7</b> 19 <b>62</b> and that death occurred at <b>11:50 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Blaine H. Etg.</b>		22b. DATE SIGNED <b>Jan 8, 1962</b>	
22c. PHYSICIAN'S NAME (Type or print) <b>BLAINE H. ETG. M.D.</b>		22d. ADDRESS <b>8641 Colesville Rd Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-11-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b> ADDRESS <b>Riverdale, Md.</b>		25a. RECD BY REGISTRAR <b>DATE JAN 11 '62</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

00833

CERTIFICATE OF DEATH

Washington, D.C.  
12/11/1918  
Washington Carbon Sanitarium

Pauline Melser

Sept. 2, 1889

Germany

Houswife

Pauline Melser

Pauline Melser

Wm. C. HINGMAN

Pauline Melser  
12/11/1918  
Washington Carbon Sanitarium  
Died of influenza  
Buried in the  
National Cemetery  
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

M

74

I

2

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00876

00868

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in lb <u>2 1/2 days</u>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Big Woods) Dickerson</u>															
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rhoda N. Mercer</u>				4. DATE OF DEATH Month Day Year <u>JAN 21 1962</u>															
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 19 1893</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Henry Orley</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Harlow</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>4</u>				17. INFORMANT (Name and address) <u>John T. Mercer - Item # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO <u>Arteriolonephrosclerosis</u> (b) <u>DIABETES MELLITUS</u> (c) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1962</u> to <u>Jan 20, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 20, 1962</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>John A. Maganzini</u>				22b. DATE SIGNED <u>1/21/62</u>															
22c. PHYSICIAN'S NAME (Type) <u>H. C. Maganzini</u>				22d. ADDRESS <u>Rockwell End Rockville</u>															
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE THEREOF <u>1/24/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockwell End</u>				25a. REC'D BY REGISTRAR <u>Arthur L. Harris</u>				25b. REGISTRAR'S SIGNATURE							
				DATE <u>JAN 25 '62</u>															

(M)

00875

Montgomery  
Baltimore  
Suburban Heights

Montgomery  
(Baltimore)

Flake  
James Earl Ray  
James Earl Ray  
James Earl Ray

James Earl Ray  
James Earl Ray  
James Earl Ray

James Earl Ray  
James Earl Ray  
James Earl Ray

Robert I. ...  
James Earl Ray  
James Earl Ray  
James Earl Ray



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death is not reported to the health department, the certificate may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00877

CERTIFICATE OF DEATH

Item 1 Film G305 1/12/62 iwk

00869

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN lb <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>34 Wheaton</b> d. STREET ADDRESS <b>12128 Bluehill</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>A.</b> Last <b>Miller</b> 4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1962</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov-19-1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>1</b> yrs. <b>17</b> Days <b>16</b> Hours <b>16</b> Min.
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND -</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Andrew Miller</b>		14. MOTHER'S MAIDEN NAME <b>MARY E McCauley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph A. Miller-Father-Same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute respiratory infection, influenza?</b> 4 <input checked="" type="checkbox"/> X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>no</b> <input checked="" type="checkbox"/> <b>yes</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>may</b> 19 <b>61</b> , to <b>Jan 5</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>January 3, 1962</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Belden R. Reap M.D.</b>		22b. DATE SIGNED <b>January 5, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		22d. ADDRESS <b>11502 GRANDVIEW AVE, SILVER SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/8/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25. REC'D BY REGISTRAR <b>JAN 9 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



00877

Montgomery

W. H. H. H.

1915

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00878

## CERTIFICATE OF DEATH

00870

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>20 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Saint Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood</b> d. STREET ADDRESS <b>"Sotterley" Estate</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Edward</b> Middle <b>(No middle name)</b> Last <b>Milton</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>16</b> Year <b>1962</b>													
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>18 November 1908</b>		<b>9. AGE</b> (In years last birthday) <b>53</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Curator</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Massachusetts</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>Joseph John Newton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Cora Oberman</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes World War II</b>				<b>16. SOCIAL SECURITY NO.</b> <b>113-07-4207</b>		<b>17. INFORMANT</b> Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>205X</b> (b) <b>Mycosis fungoides</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b> <b>6 Years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>									
<b>21. I certify that</b> <b>He</b> (this hospital) attended the deceased from <b>December 27, 1961</b> to <b>January 16, 1962</b> that <b>ix</b> (we) last saw the deceased alive on <b>January 16, 1962</b> , and that death occurred at <b>1:05 PM</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <b>Frederick H. Welland, M.D.</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>1-16-61</b>		<b>22b. DATE SIGNED</b>											
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Frederick H. Welland, M.D.</b>				<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>1/17/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Crematory</b>		<b>23d. LOCATION (City, town or county)</b> <b>(State)</b> <b>Suitland, Maryland</b>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Joseph F. Birch's Sons</b>				<b>ADDRESS</b> <b>Washington, D. C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 19 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Cosling S. Hines</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

*22 Hry cock*

87300

1. Name \_\_\_\_\_  
2. Address \_\_\_\_\_  
3. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
4. Telephone \_\_\_\_\_  
5. E-mail \_\_\_\_\_  
6. Date \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00879

CERTIFICATE OF DEATH

Reg. Dist. No. 00879

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>17 years</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>1709 Corwin Drive</u>		d. STREET ADDRESS <u>1709 Corwin Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth</u> <u>MARY</u> <u>MISTER</u>		4. DATE OF DEATH <u>JANUARY</u> <u>28</u> <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 5, 1899</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR <u>63</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Moberly, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Sherman ORR</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-36-4482</u>	
17. INFORMANT <u>Daughter (Margaret)</u>		Address <u>SAME as 2d.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(probable) overwhelming Infection</u> DUE TO <u>Subacute Aleukemic Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> 19 <u>62</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>56</u> , to <u>27 JAN</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>27 JAN</u> , 19 <u>62</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>4500 College Ave., Prince Georges, Maryland</u>	
ACTUAL SIGNATURE <u>Frederick Barr</u> M.D.		DATE SIGNED <u>1-28-62</u>	
PHYSICIAN'S NAME (Type) <u>F. Frederick BARR, MD</u>		<u>College Park, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>Georgia Ave. Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-31-62</u>	
24b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>			

CERTIFICATE OF DEATH

10239

NAME OF DECEASED William Sherman Carr		AGE 47		SEX Male		RACE White		DATE OF BIRTH 1892		PLACE OF BIRTH New York	
DATE OF DEATH 1939		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease	
OCCUPATION Teacher		EDUCATION High School		RELIGION Methodist		MARRIAGE Married		SPOUSE Mary Carr		CHILDREN 3	
BURIAL PLACE Carr Cemetery		DATE OF BURIAL 1939		NAME OF FUNERAL HOME Carr Funeral Home		NAME OF MINISTER Rev. J. H. Carr		NAME OF CHURCH First Methodist Church		NAME OF CEMETERY Carr Cemetery	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF MINISTER (None)		SIGNATURE OF FUNERAL HOME (None)		SIGNATURE OF CEMETERY (None)	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4514 Courtland Rd</u>		d. STREET ADDRESS <u>1 4514 Courtland Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret M CREAGER Moore</u>		4. DATE OF DEATH Month Day Year <u>Jan 17 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-1899</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis I. Creager</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Leary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-6295</u>	
17. INFORMANT Address <u>J. N. Moore, Husband-same 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of blood</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute Alcoholism</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead at foot of stairs where she had fallen</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1-17-62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda mnty md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BLASZCZAK</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 19 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

00882



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00873

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fairway Hills</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>59 Fairway Hills</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6212 Vorlick Lane</b>				d. STREET ADDRESS <b>1 6212 Vorlick Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>MARCEL</b> Middle <b>J.</b> Last <b>MOREAU</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>31,</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1902</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Paris, France</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA-Nat.</b>			13. FATHER'S NAME <b>Alphonse Moreau</b>				
14. MOTHER'S MAIDEN NAME <b>Eugenia Maitralain</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>577-09-3764</b>			17. INFORMANT <b>Wife</b> <b>Charlotte Moreau</b>		Address <b>Same as #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b></b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b></b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Jan. 31, 1962</b> Address (Street, city, town, or county) <b></b>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/3/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 5 '62</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

MEDICAL CERTIFICATION

2

(M)

00281

Rayway Hills

6212 North Star Lane

10701

Wash. D.C.

1st St. & 1st Ave.

Alphonse Brown

57-05-2704 Charlotte Harbor

Company description

Butter 2/3/82

General Hotel Cemetery

1001 N. 1st St., Tampa, Florida

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00882

00874

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>512 Harding Dr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Philip (NMN) Morris</u>				4. DATE OF DEATH <u>1 27 1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-09</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing Machine Vacuum Cleaner</u>			
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Moses Shlionsky</u>				14. MOTHER'S MAIDEN NAME <u>Yetta</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-05-3710</u>			
17. INFORMANT <u>Mrs Sylvia Morris</u>				Address <u>Wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Collapsed on floor at his office while at work</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-27-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/28/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Mem. Park</u>	
22d. LOCATION (City, town, or country) <u>Falls Church, Va.</u>				(State)			
23. FUNERAL DIRECTOR ADDRESS <u>Goldberg Funeral Home 4217 9th Street N.W.</u>				24a. REC'D BY REGISTRAR <u>JAN 29 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

00882

Page 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physician may be called by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 91 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pequea (Rural)			75 x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.					d. STREET ADDRESS R.D. # 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kenneth Glenn Morrison					4. DATE OF DEATH Month Day Year January 25, 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 July 1949		9. AGE (In years last birthday) 12 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Glenn R. Morrison					14. MOTHER'S MAIDEN NAME Florence Reinhart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Lower lobe pneumonia 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Staphylococcal septicemia (c) Acute Lymphocytic leukemia								INTERVAL BETWEEN ONSET AND DEATH Days Days 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathologic fracture Right & Left femoral neck, compression fractures								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) compression fractures L2&L3							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (A) (this hospital) attended the deceased from October 26, 1961 to January 25, 1962, that (I) (we) last saw the deceased alive on January 25, 1962, and that death occurred at 12:10 PM from the causes and on the date stated above.									
22a. SIGNATURE Frederick H. Welland, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1-25-62			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frederick H. Welland, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 29, 1962		23c. NAME OF CEMETERY OR CREMATORY Colemanville Cem		23d. LOCATION (City, town or county) (State) Conestoga Twp. Penna			
24. FUNERAL DIRECTOR'S SIGNATURE R. L. Duncan				ADDRESS Falls Church Va		25a. REC'D BY REGISTRAR JAN 29 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00884

00876

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Montgomery</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres</b>		c. LENGTH OF STAY IN 1b <b>57</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres</b>		d. STREET ADDRESS <b>6008 Cobalt Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6008 Cobalt Road</b>				d. STREET ADDRESS <b>6008 Cobalt Road</b>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Bert</b> Middle <b>W</b> Last <b>Morrow</b>				<b>4. DATE OF DEATH</b> Month <b>Jan</b> Day <b>26</b> Year <b>19 62</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/15/04</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Office Dept.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Iowa</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>A. M. Morrow</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Lindquist</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 2</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Nella Morrow-Wife-same 2d</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of stomach with</b> DUE TO <b>metastases to retroperitoneal glands</b> Conditions, if any, which gave rise to immediate cause (b) <b></b> (c) <b></b> DUE TO <b></b> (e), stating the underlying cause last. <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Pernicious anemia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>one year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>									
20c. TIME OF INJURY Hour <b></b> e.m. <b></b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>		(State) <b></b>			
21. I certify that (I) (this hospital) attended the deceased from <b>March 25, 1961</b> , to <b>Jan 26, 1962</b> that (I) <b>( )</b> last saw the deceased alive on <b>Jan 26, 1962</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Saul Hottzman</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1/26/62</b>							
22c. PHYSICIAN'S NAME (Type) <b>Saul Hottzman</b>						22d. ADDRESS <b>1800 Eye St. NW Wash DC</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/29/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>						25a. REC'D BY REGISTRAR <b>FEB 1 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>					

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Montgomery

Woodbridge

6008 Cobalt Road

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Post Office Dept.

J. M. Minton

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00885

008877

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3702 Randolph Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALICE</b> First Middle Last <b>MUMME</b>				4. DATE OF DEATH <b>January 7, 1962</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 13, 1901</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sears Roebuck &amp; Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>	
13. FATHER'S NAME <b>William Hampton</b>				14. MOTHER'S MAIDEN NAME <b>Belle Blair</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>578-16-1247</b>		17. INFORMANT <b>Wm. J. F. Mumme-Item# 2</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>175.0</b> DUE TO <b>Carcinoma ovaries with generalized metastasis</b> Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>4 mon.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 5, 1961</b> , to <b>Jan. 7, 1962</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Jan. 6, 1962</b> , and that death occurred <b>11:50 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>P P Andrews</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-7-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>P.P. Andrews</b>				22d. ADDRESS <b>4201 Fessenden St., N.W., Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/10/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 11 '62</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be made by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MONTGOMERY STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00886 CERTIFICATE OF DEATH 00878											
Items 7 & 23b, Film G305 1/12/62 iwk											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN TB <b>10 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>Hamilton Blvd.</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Simon Jerome Murphy</b>				4. DATE OF DEATH Month Day Year <b>January 6 1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>February 27, 1890</b>		9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Palmer</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Agnes Balmond (Sister)</b>		Address <b>Hagerstown, Md. 1032 Hamilton Blvd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia, left lung, organism unidentified</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 28, 1961</b> , to <b>January 6, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 January 1962</b> , and that death occurred <b>6:55 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>D. L. Kettering</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>D. L. KETTERING, LT MC USN</b>						22d. ADDRESS <b>US Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/10/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Jeanette, Pennsylvania</b>			
24. FUNERAL HOME'S SIGNATURE <b>W. Warren Taltavull Funeral Home, 3603 14th St NW</b>						ADDRESS <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

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U.S. Navy Hospital, Bethesda, Md.  
Bethesda (Md.)  
In care  
Hagerstown  
Maryland

U.S. Navy  
California  
Simon  
January  
February 24, 1950  
Pennsylvania

William Murphy  
Lucy Fisher  
Hagerstown, Md.  
Hagerstown (Md.)  
Hagerstown River

X

January 1950  
December 28, 1950

U.S. Navy Hospital, Bethesda, Md.  
Bethesda, Md.  
Hagerstown, Md.  
Hagerstown River  
Hagerstown, Md.  
Hagerstown River  
Hagerstown, Md.  
Hagerstown River

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00887 114879											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>185 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waukegan</b> d. STREET ADDRESS <b>516 Oakwood Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>CHARLOTTE</b> Last <b>MURRAY</b>						4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 14, 1909</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Bert Magness</b>						14. MOTHER'S MAIDEN NAME <b>Nancy Brown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus, suspected</b> DUE TO <b>199X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Malignant Carcinoid with Metastases</b> DUE TO (c) <b>18 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>199X</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (this hospital) attended the deceased from <b>July 11, 1961</b> to <b>January 12, 1962</b> that (we) last saw the deceased alive on <b>Jan. 12, 1962</b> , and that death occurred at <b>6:35 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William B. Kremer</b> M.D.						22b. DATE SIGNED <b>January 12, 1962</b>					
22c. PHYSICIAN'S NAME (Type) <b>William B. Kremer</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL. (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-13-1962</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State) <b>Waukegan, Illinois</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyung Co - 1300 N. St. N.W. WASH. D.C.</b>						25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>C. H. S. H. H.</b>			



00000

Montgomery

Illinois

Bedford

185 Days

Washington

The Clinical Center

200 Oakwood Street

HILL

CHARLES

MURRAY

January 12, 1952

52

Female

February 12, 1952

Honolulu

Hawaii

Indiana

USA

William Burt Johnson

Henry Brown

The Medical Record

No

Not available The Clinical Center, Bedford, Mass., England

Unusual, unusual, suspected

Immediate

Assignment of staff in with laboratory

12-12-52

x

Jan. 12, 1952

July 12, 1952

Institute of Health, Bedford, Mass., No. 1  
The Clinical Center, National  
X-12-12-52

1-12-52

WORK - 12-12-52

12-12-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 14 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 14 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00888

00880

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>37 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>California</b> b. COUNTY <b>Lancaster</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45051 Redwood Avenue</b> d. STREET ADDRESS <b>43 X 3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernice Ruth Muscardine</b>		4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1921</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>40</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Air Force</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Aleck Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Zura Ida Grogan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>466-22-4494</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 754-5 DUE TO <b>Extensive pulmonary congestion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>leading to marked respiratory insufficiency.</b> DUE TO <b>Congenital heart disease with total anomalous pulmonary venous drainage and atrial septal defect,</b> (c) <b>(corrected); persistent left superior vena cava.</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>		20. INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>	
21. INTERVAL BETWEEN ONSET AND DEATH <b>40 years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>December 8, 1961</b> to <b>January 14, 1962</b> that <b>10</b> (we) last saw the deceased alive on <b>January 14, 1962</b> , and that death occurred at <b>1:25 P.M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>R.P. Anderson</b> M.D.		22b. DATE SIGNED <b>January 15, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard P. Anderson</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1/16/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>--</b>		23d. LOCATION (City, town or county) (State) <b>Deport, Texas</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b> <b>2901 14th St., N.W.</b> <b>Washington 9, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Clifton L. Brown</b>			

00000

(M)

Montgomery

Bedford

38 days

California

Lawrence

15001 Redwood Avenue

The Clinical Center, Bethesda, Md.

Washington

South

Service

x

June 8, 1951

White

Female

(I)

Civil Service Employee

U.S. Air Force

Texas

John Jacob Griffin

From the Program

The Medical Record

100-22-1001 The Clinical Center, Bethesda, Md., Maryland

No

U.S. Army

to five units of patients

U.S. Army Medical Institute

U.S. Army Medical Institute

U.S. Army Medical Institute

(corrected) : omitted self superior value

December 8, 1951 January 11, 1952

January 11, 1952

Richard J. Harrison

1/10/1952

Report, extra

The Clinical Center, Bethesda, Md.  
Institution of Health, Bethesda, Md.

The U.S. Army Medical Institute  
Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY in 1b <b>1 HR. 25 MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b> d. STREET ADDRESS <b>MC KENDREE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HERBERT HOBBS MUSGROVE</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 31 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-92</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months Days <b>70</b>	IF UNDER 24 HRS. Hours Min. <b>13 X 2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>STEPHEN WASHINGTON MUSGROVE</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE LOUISE HOBBS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>214-28-0131</b>	
17. INFORMANT <b>HOSPITAL RECORD</b>		Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>5 HOURS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from..... <b>July 50</b> ....., 19..... <b>50</b> to..... <b>JAN 31 62</b> ....., 19..... <b>62</b> that (I) (the) last saw the deceased alive on..... <b>JAN 31 1962</b> ..... and that death occurred at..... <b>3:45 PM</b> ..... from the causes and on the date stated above.	22a. SIGNATURE <b>Charles S. Whitaker, M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>		
22b. DATE SIGNED <b>Feb 1, 1962</b>		22d. ADDRESS <b>CLARKSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 3, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Howard County, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>		25. REC'D BY REGISTRAR <b>FEB 5 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>	

00889

M

MONTGOMERY

OLNEY

MONTGOMERY GENERAL HOSPITAL

HERBERT

MOORE

USGROVE

JANUARY

11

63

WHITE

1-22-63

10

RETHIER PARKER

MARYLAND

U. S. A.

STEPHEN WASHINGTON USGROVE

WILLIE LOUISE MOORE

OLNEY, MARYLAND

OLNEY, MARYLAND

UNKNOWN

OLNEY, MARYLAND

OLNEY, MARYLAND

OLNEY, MARYLAND

OLNEY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00890						00882					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Montgomery</b>						e. STATE <b>Florida</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Bethesda</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>St. Petersburg</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, NMMC</b>						d. STREET ADDRESS <b>2598, 46 Terrace N.</b>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <b>Dallas Meredith NEAL</b>						Month Day Year <b>January 21 1962</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 November 1906</b>		9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Thomas Neal</b>						14. MOTHER'S MAIDEN NAME <b>Ettie Mae Alexander</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>				16. SOCIAL SECURITY NO. <b>136-32-3354</b>		17. INFORMANT Address <b>Wife-Mrs. Fyrn L. Neal, 2598, 46 Terrace N., St. Petersburg, Fla.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell Carcinoma of the bronchus.</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <del>10</del> (this hospital) attended the deceased from <b>18 January, 1962</b> , to <b>21 January, 1962</b> , that <del>1</del> (we) last saw the deceased alive on <b>21 January, 1962</b> , and that death occurred at <b>4:05 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>P.G. Linaweaver, LCDR MC USN</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>P.G. Linaweaver, LCDR MC USN</b>						22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-23-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial</b>				23d. LOCATION (City, town or county) (State) <b>St. Petersburg, Florida</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. PUMPHREY</b>						ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 24 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

00280

CONTINUED ON REVERSE

(Name) Bethesda

3 days

100-100000

U.S. Naval Hospital, HMC

2500, 40 Service H.

100-100000

100-100000

WAL

January 21

100-100000

100-100000

5 November 1900

100-100000

100-100000

Tennessee

100-100000

John Thomas Neal

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

U.S. Naval Hospital, Bethesda, Md.

P.O. 100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
M  
90  
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00891

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY in 1b <u>2 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>478-3</u> d. STREET ADDRESS <u>4624 Wisconsin Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES B. NEHRING</u> First Middle Last				4. DATE OF DEATH <u>JAN 6 1962</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1880</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Board of Trade-Chicago, Ill.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Nehring</u>				14. MOTHER'S MAIDEN NAME <u>Minnie (unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>321-03-1493</u>		17. INFORMANT <u>Mr. W. R. Chapline</u>		Address <u>4225 43rd St. N.W. D.C. 6</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2 mos. Coronary Artery Heart Disease</u> DUE TO <u>10 years Arteriosclerosis, Generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>Congestive Heart Failure, Arteriosclerotic Heart dis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Nov. 9, 1961</u> to <u>January 6, 1962</u> that (I) ( <del>was</del> ) last saw the deceased alive on <u>January 5, 1962</u> , and that death occurred at <u>9:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Belden R. Reap M.D.</u>		22b. DATE SIGNED <u>January 6, 1962</u>		22c. PHYSICIAN'S NAME (Typed) <u>BELDEN R. REAP, M.D.</u>		22d. ADDRESS <u>Wheaton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/8/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. Lincoln crematory</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Harris Co. 2901-14th St. N.W.</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

Wash. 9, D.C.

(M)

(T)

CHARLES J.

NEHRING

1943, 1944

1943, 1944

Registered - Howard T. Lee - Chicago, Ill.

John Nohring

Minia (unknown)

1943-1944

no

Country of origin

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Country of origin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00892

00884

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Silver Spring</b>					
c. LENGTH OF STAY IN 1b <b>4 mos.</b>				d. STREET ADDRESS <b>1915 Glen Ross Road</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitorium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sallie F. Nelson</b>				4. DATE OF DEATH Month Day Year <b>Jan. 29 1962</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 6, 1876</b>			
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>11 22</b>		IF UNDER 24 HRS. <b>11 22</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>					
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>J. Phillip Fogarty</b>				14. MOTHER'S MAIDEN NAME <b>Johanna Cahill</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Mrs. Lewis Phelps-Sister-Chevy Chase, Md</b>				Address <b>3707 Shephard St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO <b>4-2-0-0-0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>157 Jan 29 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 29 1962</b> , and that death occurred at <b>4:20 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>J. Marion Bankhead</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/29/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. Marion Bankhead</b>				22d. ADDRESS <b>9241 Col. Blvd. Silver Spring, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>1/30</b>			
25b. REGISTRAR'S SIGNATURE <b>Anthony S. ...</b>									

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Very truly

Respectfully

Yours very truly

W. H. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00893

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> d. STREET ADDRESS <b>88 Hollingsworth Manor</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>(None)</b> Last <b>Newton</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1880</b> <b>August 27, 1880</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Newton</b>		14. MOTHER'S MAIDEN NAME <b>(First name unknown) Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastric ulcer</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b> <b>4 Weeks</b>	
20a. A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 26, 1961</b> to <b>January 16, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 16, 1962</b> , and that death occurred at <b>9:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick H. Welland, M.D.</b>		22b. DATE SIGNED <b>1-16-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frederick H. Welland, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/19/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>West Laurel Hill Cemetery, Philadelphia, Pa.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks, Elkton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

100000



Montgomery

Maryland

1000

Bedford

21 days

1000

The Clinical Center, Bethesda, Md.

68 Hollingworth Ave.

1000

(None)

1000

1000

1000

Male

White

x

August 27, 1970

28

Center

Emergency

Michigan

U.S.A.

John Newton

(First name unknown) Clark

The Medical Record

Unsubstantiated The Clinical Center, Bethesda, Md.

to

bronchopneumonia, bilateral

1 day

acute pulmonary infection

1 day

Gastroenteric

x

January 16

1000

December 25 of January 16

The Clinical Center, National  
Institution of Health, Bethesda, Md.

Professor H. Holland, M.D.

1/16/62 West Laurel Hill Cemetery, Philadelphia, Pa.

John E. Newton, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00894					00886				
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>3 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>324 Cedar Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Douglas Nuse Jr.</u>					<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>31</u> Year <u>1962</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1/31/62</u>		<b>9. AGE (In years last birthday)</b> yrs. <u>3</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>	
<b>13. FATHER'S NAME</b> <u>James Douglas Nuse, Sr.</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lois Pace</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Father</u> Address <u>same as above</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>7625</u> <u>atelectasis</u> <u>Prematurity</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>2 1/2 hrs</u>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a.m. <u>10</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <u>Rockville</u>		<b>(County)</b> <u>Montgomery</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2:18 PM</u> , 19 <u>62</u> , <b>to</b> <u>10:15 PM</u> , 19 <u>62</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>10 PM</u> , 19 <u>62</u> <b>and that death occurred at</b> <u>10:15 PM</u> , <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Francis J Troendle M.D.</u>					<b>22b. DATE SIGNED</b> <u>10/31/62</u>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>FRANCIS J TROENDLE</u>					<b>22d. ADDRESS</b> <u>809 Viers Mill Rd, Rockville Md</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-2-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Park Heights</u>		<b>23d. LOCATION (City, town or county)</b> <u>Brunswick mcs.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Fete Funeral Home Brunswick md</u>					<b>25a. REC'D BY REGISTRAR</b> <u>FEB 6 62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00895  
CERTIFICATE OF DEATH

00887

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>Since 2-12-61</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Josephine A. Parce</b>		4. DATE OF DEATH Month Day Year <b>JAN. 5 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25-1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Bolder, Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles B. Andersen</b>		14. MOTHER'S MAIDEN NAME <b>Catharine Norberg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>John R. Parce 3906 Washington st. Kensington, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aortic Aneurysm</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Atherosclerosis</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 12, 1961</b> to <b>Jan 5, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 4, 1962</b> , and that death occurred at <b>1:20 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George Sharpe MD</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>George Sharpe, MD</b>		22d. ADDRESS <b>10,511 Summit Ave., Kensington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-8-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Prince George County Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey Inc.</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Catharine S. Kraus</b>			

00295



Charles B. Anderson  
Botanizing Herbar

Received of Robert H. Anderson  
the sum of \$10.00

July 13, 1913  
Silver Spring, Md.

Received of Robert H. Anderson  
the sum of \$10.00  
Silver Spring, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00896

00888

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Montgomery</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darnestown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darnestown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9110 Darnestown Road</b>				d. STREET ADDRESS <b>9110 Darnestown Road</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Harold McElwan Pease</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>7</b> Year <b>19 62</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2/25/94</b>	
<b>9. AGE</b> (In years last birthday) <b>67</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Carpentering</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Massachusetts</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Arthur Pease</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Lura McElwan</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes WW 1</b>				<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> <b>Ruby T. Pease-Wife-same 2d</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CHRONIC CORONARY INSUFFICIENCY</b> DUE TO (c) <b>ARTERIO SCLEROSIS</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>30 MINUTE</b> <b>20 YEARS</b> <b>20 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 10, 1960</u> to <u>JAN 7, 1962</u> that (I) (we) last saw the deceased alive on <u>DEC 15, 1961</u>, and that death occurred at <u>10A</u> M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Gordon S. Rosenberger</i>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <i>Jan 7, 1962</i>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Gordon S. Rosenberger, M.D.</b>				<b>22d. ADDRESS</b> <b>310 W. Montgomery Ave, Rockville, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>1/10/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Crematory</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Suitland, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey, Bethesda, Maryland</b>				<b>25e. REC'D BY REGISTRAR</b> <b>JAN 15 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Haines</i>	

(M)

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PROPERTY

MARYLAND

WATERGATE

WATERGATE

1110 Watergate Road

1110 Watergate Road

Harold

William

Leah

January 7

White

White

of

Robert

Robert

Yes

Yes

Unknown

Ann V. Benson-Wilson

Robert A. Rosenberg, N.Y. 310 W. Montgomery Ave, Rockville, Md.

Robert A. Rosenberg, Bethesda, Maryland

Robert A. Rosenberg, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00897

00889

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>23 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Atlantic City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>67X-3</b> d. STREET ADDRESS <b>534 Spring Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Coletta Denise Peeler</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>January 9 1962</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 19, 1961</b>
<b>9. AGE</b> (In years last birthday) <b>7 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New Jersey</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>Dodson Louie Peeler</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mildred Louise Tharpe</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>The Medical Record</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest, operative</b> 754- } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Congenital Heart Disease - Ventricular Septal Defect &amp; Patent Ductus Arteriosus</b> (c) <b>Defect &amp; Patent Ductus Arteriosus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 am. o.</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. INJURY OCCURED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>Atlantic City N.J.</b>	
<b>21. I certify that (X) (this hospital) attended the deceased from December 17, 1961, to January 9, 1962, that (X) (we) last saw the deceased alive on January 9, 1962, and that death occurred at 10:40 AM on the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Richard P. Anderson</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Richard P. Anderson, M.D.</b>		<b>22b. DATE SIGNED</b> <b>1-9-62</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Jan. 11, 1962</b>		<b>23b. DATE THEREOF</b> <b>Jan. 11, 1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Trayer's Funeral Home, Inc. 389-R. D. Ave.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Atlantic City N.J.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Trayer's Funeral Home, Inc. 389-R. D. Ave.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 11 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Tharpe</b>			

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The Division Center, Bethesda, Md.,  
33, Spring Lane

January 1, 1951  
The Division Center, Bethesda, Md.

The Division Center, Bethesda, Md.,  
33, Spring Lane

Enclosed for the Division Center, Bethesda, Md.,  
33, Spring Lane

January 1, 1951  
The Division Center, Bethesda, Md.

Enclosed for the Division Center, Bethesda, Md.,  
33, Spring Lane



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00898

00890

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission)			
a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN lb <i>13 days 13 1/2 hrs</i>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>8906 Kines Street</i>	
<b>3. NAME OF DECEASED</b> (Type or print) <i>Elizabeth NMN Pfeuffer</i>				<b>4. DATE OF DEATH</b> Month <i>January</i> Day <i>8</i> Year <i>1962</i>			
<b>5. SEX</b> <i>female</i>		<b>6. COLOR OR RACE</b> <i>white</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>JANUARY 23, 1880</i>	
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10a. KIND OF BUSINESS OR INDUSTRY</b>		<b>9. AGE</b> (In years last birthday) <i>81</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <i>8</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Germany</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U. S. A.</i>					
<b>13. FATHER'S NAME</b> <i>Phillip Dinkel</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Virginia Stephan</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				<b>16. SOCIAL SECURITY NO.</b> <i>Hospital Record.</i>			
<b>17. INFORMATION</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>584</i> IMMEDIATE CAUSE (a) <i>Myocardial failure</i> DUE TO (b) <i>myocardial fibrosis + uremia</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <i>cholelithiasis + acute cholecystitis + cholangitis</i> DUE TO (c) <i>years</i>				<b>INTERVAL BETWEEN ONSET AND DEATH.</b> <i>minutes</i> <i>months to weeks</i>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <i>a.m.</i> <i>19</i> Month, Day, Year		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>6-13-1961</i> , to <i>1-8-1962</i> that (I) (we) last saw the deceased alive on <i>1-8-1962</i> , and that death occurred at <i>3 AM</i> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Charles R. Shultz, M.D.</i>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <i>1-8-62</i>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>Charles R. Shultz, M.D.</i>				<b>22d. ADDRESS</b> <i>6 Tanager Lane, Simpsonville, Md.</i>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>JAN. 11, 1962</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Luthran Cemetery</i>		<b>23d. LOCATION</b> (City, town or county) (State) <i>Blondale Queens to New York</i>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Arthur Walters</i>				<b>25a. REC'D BY REGISTRAR</b> <i>254 Carroll St. N.W. - Wash. D.C.</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hume</i>	

80300



*[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

*[Faint text at the bottom of the page, possibly a signature or footer, including the date "MAR 11 1965".]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

00899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY in 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASH. SANITARIUM &amp; HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>8439 12th AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Genevieve Clair Plummer</b>				4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>1962</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 18 1882</b>	
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b>		IF UNDER 24 HRS. Hours <b>7</b> Min. <b>9</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>DERRY PENN.</b>				12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>			
13. FATHER'S NAME <b>THEODORE WINGARD</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>?</b>			
17. INFORMANT <b>HARVEY HAUN</b>				Address <b>8439 12th AVE. SILVER SPRING</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschiant</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschiant</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>1-11-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>1/12/1962</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Coles Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Derry, Pennsylvania</b>			
23. FUNERAL DIRECTOR <b>The S. H. Hines Co.</b>				24a. REC'D BY REGISTRAR <b>2901-14th St N.W. Washington D.C.</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

(M)

THEO. WINGARD

HARVARD UNIVERSITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00900

00892

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>17220 Colesville Road</b> c. LENGTH OF STAY in 1b <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Belmont Nursing Home</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b> d. STREET ADDRESS <b>7723 Carroll Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>VIRGINIA ROBERTA PRALLE</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>January 13, 1962</b> Month Day Year	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 15, 1884</b> yrs. Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>	
<b>13. FATHER'S NAME</b> <b>Robert Clarvoe</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Jennie Lomb</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>17. INFORMANT</b> <b>G. Albert Pralle 7723 Carroll Ave Tak Pk, Md</b> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 days many years</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour min. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from 1/11/62 to 1/13/62 that (I) (we) last saw the deceased alive on 1/12/62 and that death occurred at 1:15 PM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>John P. Martin MD</b>		<b>22b. DATE SIGNED</b> <b>1/13/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JOHN P. MARTIN, MD</b>		<b>22d. LOCATION</b> (City, town or county) (State) <b>Washington, D. C.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>2/15/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rock Creek Cemetery</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Arthur Walters</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 17 '62</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hump</b>

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Central Government  
Bureau of the Interior  
Washington

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1/12/22

John P. [unclear]  
[unclear] [unclear]  
[unclear] [unclear]

1/12/22

John P. [unclear]  
[unclear] [unclear]  
[unclear] [unclear]



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00901											
111893											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>6 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LeDeau Gardens Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>3600 Conn. Ave., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Mary Morgan Purdon</b>					4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1962</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>xx</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 19, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian-Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME <b>George H. Morgan</b>					14. MOTHER'S MAIDEN NAME <b>Mary Brownson</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>579-07-4797</b>		17. INFORMANT <b>Mrs Frederick Gutheim, Dickerson, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Embolism</b> DUE TO (c) <b>Pneumonia, Bronchial</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>Stat</b> <b>2 days</b>	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sep 1961</b> to <b>Jan 20, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 19, 1962</b> , and that death occurred at <b>12:45 pm</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert T. Thibadeau</b>					22b. DATE SIGNED <b>Jan 20, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>				
22d. ADDRESS <b>10609 Concord St., Kensington, Md.</b>					22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1/20/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Prince George Co., Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</b>					25b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>						

00201

Montgomery

M

Oliver Spring

6 mo.

Lebanon Gardens Hunting Home

January 20 1883

Female  
Gastroenteric  
Oct 19, 1883

Acute Congestive Heart Failure  
Pulmonary Embolism  
Pneumonia, Bronchitis

Jan 19 82  
12:45 p  
Jan 20 82  
1:00 p

Robert T. Tristram, M.D. 10609 Concord St., Kensington, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN b <b>76 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Md.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> d. STREET ADDRESS <b>5913 Essex Court, SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>George Thomas Rael</b>					4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 62</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 October 1946</b>		9. AGE (In years last birthday) <b>15</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Mr. George J. Rael</b>					14. MOTHER'S MAIDEN NAME <b>Ruth T. Picton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>mother-Mrs. Ruth T. Clayton Same as #2</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Lymphocytic Leukemia</b> DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>14 Nov. 1961</b> to <b>26 Jan. 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>26 Jan. 1962</b> and that death occurred at <b>9:45 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>D. L. Kettering, LT MC USN</b>					ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-26-62</b>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-29-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Suitland</b>			23d. LOCATION (City, town or county) <b>Suitland, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Funeral Home, Good Hope Rd., Anacostia, D.C.</b>						25a. REC'D BY REGISTRAR <b>DOAN 3 0 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	



0303

Director of Colorado

Washington, D. C.

2013 Annex Court, SE

January

1941

28 October 1940

Washington, D. C.

Rich T. Pison

Wichita-Miss. Rich T. Clayton 2nd and 42

Advisory Committee

Mr. George J. Ruel

no

20 Jan

14 Nov

2:42 PM

20 Jan

1-28-42

U. S. Naval Hospital, Bethesda, Md.

Bethesda, Md.

D. L. Koster, Jr. MD USN

Medical

Simons Funeral Home, 604 Hope Rd., Annapolis, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00903 Item 21 Film G305 1/9/62 iwk 00895											
1. PLACE OF DEATH											
a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>6 days</b>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b> <b>500 Pearl Street</b>											
2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)											
a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>1011-2</b>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Jo Anne Reid</b> 4. DATE OF DEATH <b>January 1, 1962</b>											
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>March 29, 1959</b> 9. AGE (In years last birthday) <b>2</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>James R. Reid</b> 14. MOTHER'S MAIDEN NAME <b>Louise Pinney</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO <b>587.2</b> Cystic fibrosis of pancreas											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>December 26, 1961</b> to <b>January 1, 1962</b> , that (I) (we) last saw the deceased alive on <b>January 1, 1962</b> , and that death occurred at <b>1:30AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William T. Butler MD</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1-1-62 22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <b>William T. Butler, M.D.</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Jan. 4, 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b> 25a. REC'D BY REGISTRAR <b>JAN 4 1962</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>											

(M)

(1)

U. S. ROBINSON & CO., INC.,  
NEW YORK, N. Y.

WILLIAM T. BUTLER

THE NATIONAL ASSOCIATION  
OF REAL ESTATE BROKERS  
OF THE UNITED STATES  
OF AMERICA  
INCORPORATED  
JANUARY 1, 1912  
NEW YORK, N. Y.



## CERTIFICATE OF DEATH

Reg. Dist. No. 11896

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONT.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUMNER</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUMNER 57</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5116 SCARSDALE RD.</b>				d. STREET ADDRESS <b>5116 SCARSDALE RD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MRS ANNIE B REYNOLDS</b>				4. DATE OF DEATH <b>Jan. 26 1962</b>			
5. SEX <b>FEMALE WHITE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 14 1882 79 yrs.</b>	
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR <b>Months Days Hours Min.</b>		IF UNDER 24 HRS. <b>Months Days Hours Min.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Dr. V. V. Korman Munnithusen</b>				14. MOTHER'S MAIDEN NAME <b>Annie Farnandis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Edwin Wood, Sumner Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute coronary insufficiency</b> DUE TO (b) <b>Acute coronary occlusion</b> DUE TO (c) <b>coronary Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>5 minutes</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-22</b> , 1962, to <b>1-26</b> , 1962, that I last saw the deceased alive on <b>1-24</b> , 1962, and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Russell M. Tilly, Jr.</b> M.D. <b>4701-Mass. Ave. N.W.</b> <b>1-26-62</b>				ADDRESS (Street, city or town, state) <b>Wash. D.C.</b>			
PHYSICIAN'S NAME (Type) <b>Russell M. Tilly Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home</b> <b>5103 Wise Ave N.W.</b>				24a. REC'D BY REGISTRAR <b>JAN 29 1962</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN b <b>20 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Md.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Levittown</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Levittown</b> d. STREET ADDRESS <b>30 Picwick Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Lisa</b> Middle <b>Machelle</b> Last <b>Rice</b>					4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>19 October 1961</b>		9. AGE (In years last birthday) <b>3</b> yrs. IF UNDER 1 YEAR Months <b>10</b> Days <b>3</b> Hours <b>10</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert D. Rice</b>					14. MOTHER'S MAIDEN NAME <b>Betty J. Parks</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5</b> DUE TO <b>Congenital Heart Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Congenital Heart Disease</b> (c) <b>3 mos.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>3 mos.</b>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (if this hospital) attended the deceased from <b>8 Jan</b> 19 <b>62</b> to <b>27 Jan</b> 19 <b>62</b> that (X) (we) last saw the deceased alive on <b>27 Jan</b> 19 <b>62</b> , and that death occurred at <b>1:45 AM</b> on the causes and on the date stated above.										
22a. SIGNATURE <b>B. W. SHEPARD</b> <b>LT MC USN</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>U.S. Naval Hospital, Bethesda Md.</b>					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-30-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alto Rest Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Altoona, Pennsylvania</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> <b>Rockville, Maryland</b> <b>Tyson Wheeler 1331 E. Montgomery Ave.,</b>					25a. REC'D BY REGISTRAR <b>JAN 30 '62</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kroma</b>			

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U.S. Naval Hospital, Bethesda, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4913 Chevy Chase Blvd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Chevy Chase</b> d. STREET ADDRESS <b>4913 Chevy Chase Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>FISKE</b> Last <b>ROBBINS</b>		4. DATE OF DEATH Month <b>1</b> Day <b>15</b> Year <b>1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/81</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mass.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fredrick William Fiske</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Tiffany Hartwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service) <b>?</b>		17. INFORMANT Address <b>Mary Louise Robbins same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Failure</b> DUE TO <b>(several years)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cerebral thrombosis</b> DUE TO <b>Recent</b> <b>Pneumonia + Congestive HF Failure</b> DUE TO <b>5 wks ago</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <b>(not in hospital)</b> attended the deceased <b>about 1945</b> to <b>15 Jan 1962</b> that (I) <b>(yes)</b> last saw the deceased alive on <b>13 Jan 1962</b> and that death occurred <b>5:35</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard B. Castell</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Richard B. Castell</b>		22b. DATE SIGNED <b>15 Jan 62</b>	
22d. ADDRESS <b>Mayflower Hotel</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	23b. DATE THEREOF <b>1/16/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory Prince Georges County, Md.</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		25. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	
25a. REC'D BY REGISTRAR <b>JAN 17 '62</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00907  
114899

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>23 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash. San. &amp; Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b> d. STREET ADDRESS <b>1925 Biltmore St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fredarich</b> Middle <b>Augustus</b> Last <b>Rodgers</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>23</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-92</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b>12</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rhode Island</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Rodgers</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Coyne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Wash. San. &amp; Hosp. Records</b>	
17. INFORMANT <b>Wash. San. &amp; Hosp. Records</b>		Address <b>Wash. San. &amp; Hosp. Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate &amp; Extensive Generalized Bone metastasis</b> DUE TO (b) <b>Generalized Bone metastasis</b> DUE TO (c) <b>Terminal Left Parotitis &amp; Bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>12K</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>May 8</b>		20f. (City or town) <b>1938</b> (County) <b>Jan 23</b> (State) <b>1962</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1-23</b> to <b>Jan 23</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1-23</b> and that death occurred at <b>5:30</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Kenneth F. Laughlin</b> M.D.		22b. DATE SIGNED <b>1-23-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Kenneth F. Laughlin</b>		22d. ADDRESS <b>934 Ellsworth St. - Petting Springs, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1/27/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town or county) <b>Montgomery County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 26 '62</b>	
ADDRESS <b>-2901 14th St. N.W. Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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EXHIBIT OF DEATH

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TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00908

CERTIFICATE OF DEATH

Item 12 Film G305 1/19/62 mh

00900

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY in 1b <b>3 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83X-3</b> d. STREET ADDRESS <b>955 So. Columbus Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANCES MARGARET ROHRER</b>		4. DATE OF DEATH Month Day Year <b>JAN 13 1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-61</b>
9. AGE (In years last birthday) <b>7 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>7</b>	
11. IF UNDER 24 HRS. Hours Min. <b>7 mos</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PAUL W. REHRER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH T. TALIAFERRO</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>PAUL W. REHRER 955 S. COLMBUS ST. ARLINGTON, VA.</b>	
17. INFORMANT <b>PAUL W. REHRER 955 S. COLMBUS ST. ARLINGTON, VA.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>754.5</b> IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CONGENITAL Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MONGOLOID (DOWN'S Syndrome)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 12</b> , 19 <b>62</b> to <b>JAN 13</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>JAN 12</b> , 19 <b>62</b> , and that death occurred at <b>0930</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederic Alan Schulaner</b> M.D.		22b. DATE SIGNED <b>1/16/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERIC ALAN SCHULANER LT MC USN</b>		22d. ADDRESS <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/15/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graham Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Orange Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hines</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Hines</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE <b>JAN 16 '62</b>	

For Fitzgerald Funeral Home Arlington, Va

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U.S. National Archives  
College Park, Maryland

70908

U.S. National Archives

U.S. National Archives

FREDERIC AUGUST SCHUBERT II NO 101 U.S. NATIONAL ARCHIVES, COLLEGE PARK, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00909

Item #8-Film G305 - 1/24/62-mmb

CERTIFICATE OF DEATH

00901

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>2 hr. 55 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> X d. STREET ADDRESS <u>1726 - Wilmar. St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel M. Schafer</u>		4. DATE OF DEATH Month Day Year <u>Jan 17 1962</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/17/1894</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		9b. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Map Service</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Evans</u>		14. MOTHER'S MAIDEN NAME <u>Leona Boswell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>John Schafer</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-25-1961</u> to <u>1-17-1962</u> , that (I) <u>(see)</u> last saw the deceased alive on <u>1-17-62</u> , and that death occurred at <u>1038</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward Lewis, Jr. M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR.</u>		22d. ADDRESS <u>5800 Beech Ave. Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-22-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Va. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>		25a. REC'D BY REGISTRAR <u>4812 Deaf Ave NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		DATE <u>JAN 22 '62</u>	

20803

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00910

00902

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium + Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>1431 Somerset Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Daniel H.M.N. Schechter</b>			4. DATE OF DEATH Month Day Year <b>January 11 1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 10, 1884</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months Days <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Roumania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Isaac Schechter</b>		
14. MOTHER'S MAIDEN NAME <b>Minnie (unknown to patient)</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT Address <b>Washington Sanitarium and Hospital</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> 525X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Pulmonary Fibrosis.</b> (c) <b>525X</b> DUE TO (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>? Long duration</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Broncho pneumonia - Emphysema - Arteriosclerotic Heart Disease</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT, WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from....., 19 <b>57</b> to..... <b>1/11</b> ....., 19 <b>62</b> ; that (I) (we) last saw the deceased alive on..... <b>1/10</b> .....19 <b>62</b> and that death occurred at..... <b>11</b> .....M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Benjamin Isaacson</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/11/62</b>
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <b>7733 Alaska Ave. N.W. Washington D.C.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)		
<b>BURIAL</b>	<b>1/12/62</b>	<b>MT. ZION CEM.</b>	<b>INASPETH. L.I. N.Y.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Adalberto Hernandez</b>			ADDRESS <b>4217-9th St. S.W.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 12 '62</b>
			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00911

00903

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>1 1/2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>18 Takoma Park</b> d. STREET ADDRESS <b>508 New York Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Schoenberg</b> Last <b>Schoenberg</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>? 1882</b> 9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Lithuania</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Mendel Schaeffer</b> 14. MOTHER'S MAIDEN NAME <b>Kale ?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT (daughter) <b>Florence S Steinberg</b> Address <b>904 Highland Dr. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute myocardial infarction</b> 420.0 DUE TO <b>Anteroseptal N.D.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Anteroseptal N.D.</b> DUE TO (b) <b>Anteroseptal N.D.</b> DUE TO (c) <b>Anteroseptal N.D.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 20, 1962</b> to <b>Jan 22, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 22, 1962</b> and that death occurred at <b>10A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Herman C. Maganzini, M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>Herman C. Maganzini, M.D.</b>		22b. DATE SIGNED <b>1/22/62</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Rockville Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 24, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Falls Church, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kuma</b> ADDRESS <b>4217-9th St NW</b>		25a. REC'D BY REGISTRAR <b>JAN 25 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kuma</b>	

00211

(M)

Montgomery

Maryland

Montgomery

Bethesda

1st Street

Tolson Park

Suburban Hospital

302 New York Avenue

South

Schomberg

Jan. 22

Female - White

TO

Honolulu

Laurel Hill

U.S.A.

Mendel Schaeffer

Male -

(Dunbar)

901 Highland St.

Florence S. Schaeffer, Silver Spring, Md.

No

Bernard C. W. Schaeffer, M.D.

Rockville Medical Center

John Schaeffer, Jr.

1st Street, N.W.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00912

00904

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;"><u>MARYLAND</u></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> <span style="float: right;">c. LENGTH OF STAY IN TB <u>52 days</u></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Kansas</u> <span style="float: right;">b. COUNTY <u>Wichita</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wichita</u> <span style="float: right;">54X-3</span> d. STREET ADDRESS <u>115 S. Rutan Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Andrew</u> <u>Frank</u> <u>Schoeppel</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>January</u> <u>21</u> <u>1962</u> Month Day Year			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Senator</u>		<b>8. DATE OF BIRTH</b> <u>23 November 1894</u>			
<b>13. FATHER'S NAME</b> <u>George J. Schoeppel</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Philip</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> <u>WWI</u>		<b>16. SOCIAL SECURITY NO.</b> <u>120X22X55X</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Kansas</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism, bilateral, multiple</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (e), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20c. TIME OF INJURY</b> Hour _____ e.m. _____ p.m. _____ Month, Day, Year _____ 19 _____		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____		<b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that</b> <u>W</u> (this hospital) attended the deceased from <u>1 December</u> ....., 19 <u>61</u> , to <u>21 January</u> , 19 <u>62</u> that <u>X</u> (we) last saw the deceased alive on <u>21 January</u> .....19 <u>62</u> ., and that death occurred at <u>1255 PM</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>M. C. WILBER CDR MC USN</u>				<b>22b. DATE SIGNED</b> <u>21 January 1962</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <u>M. C. WILBER CDR MC USN</u>				<b>22d. ADDRESS</b> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-25-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Old Mission Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Wichita</u>		<b>(State)</b> <u>Kansas</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Gawler's Sons Inc., Funeral Home 1756 Penn. Ave.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>JAN 24 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

33292

TABLE 1

(1971-72) 1971-72-73

U.S. Naval Academy

1015

Correspondence:

Александров, А.А.

0-67-1987-1

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... ..



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00913

00905

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4415 Dexter Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Schooley</b>		<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>21,</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 8, 1900</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Banker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>9. AGE</b> (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Clarence E. Schooley</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lizzie L. Tiffany</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>World War 2</b>		<b>16. SOCIAL SECURITY NO.</b> <b>579-01-5279</b> <b>17. INFORMANT</b> <b>Eleanor O. (wife)</b> Address <b>same as above</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>(b) ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 MINUTES</b> <b>years -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> <b>19</b> Month, Day, Year	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec 1954</b> , 19 <b>57</b> , to <b>Jan 21</b> , 19 <b>62</b> , that (I) <del>(the)</del> last saw the deceased alive on <b>Jan 12</b> , 19 <b>62</b> , and that death occurred at <b>12 noon</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Richard F. Manegold</b> M.D.		<b>22b. DATE SIGNED</b> <b>1-21-62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Richard F. Manegold</b>		<b>22d. ADDRESS</b> <b>5255 Loughboro Rd. Dist. Columbia</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>1/24/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington, Virginia</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S. H. Hines Company-Washington, D.C.</b>		<b>25. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE JAN 23 '62</b> <b>Arthur S. Hines</b>	

00000



Montgomery

D.O.

Refund

D.O.

Washington

Shuman House

1415 Dexter Avenue, N.E.

William

E. Scholley

Jan.

St.

x

White

Feb. 8, 1900

61

Banker

Washington, D.C.

U.S.A.

Clarence E. Scholley

1415 E. 11th

270-01-5272 (after) (name in above)

World War 2



Washington, D.C.

1415 E. 11th

Jan 10 1901

Jan 10 1901

Richard F. Hennig

2525 E. 11th

Washington National Association

The S. W. Hines Company - Washington, D.C.

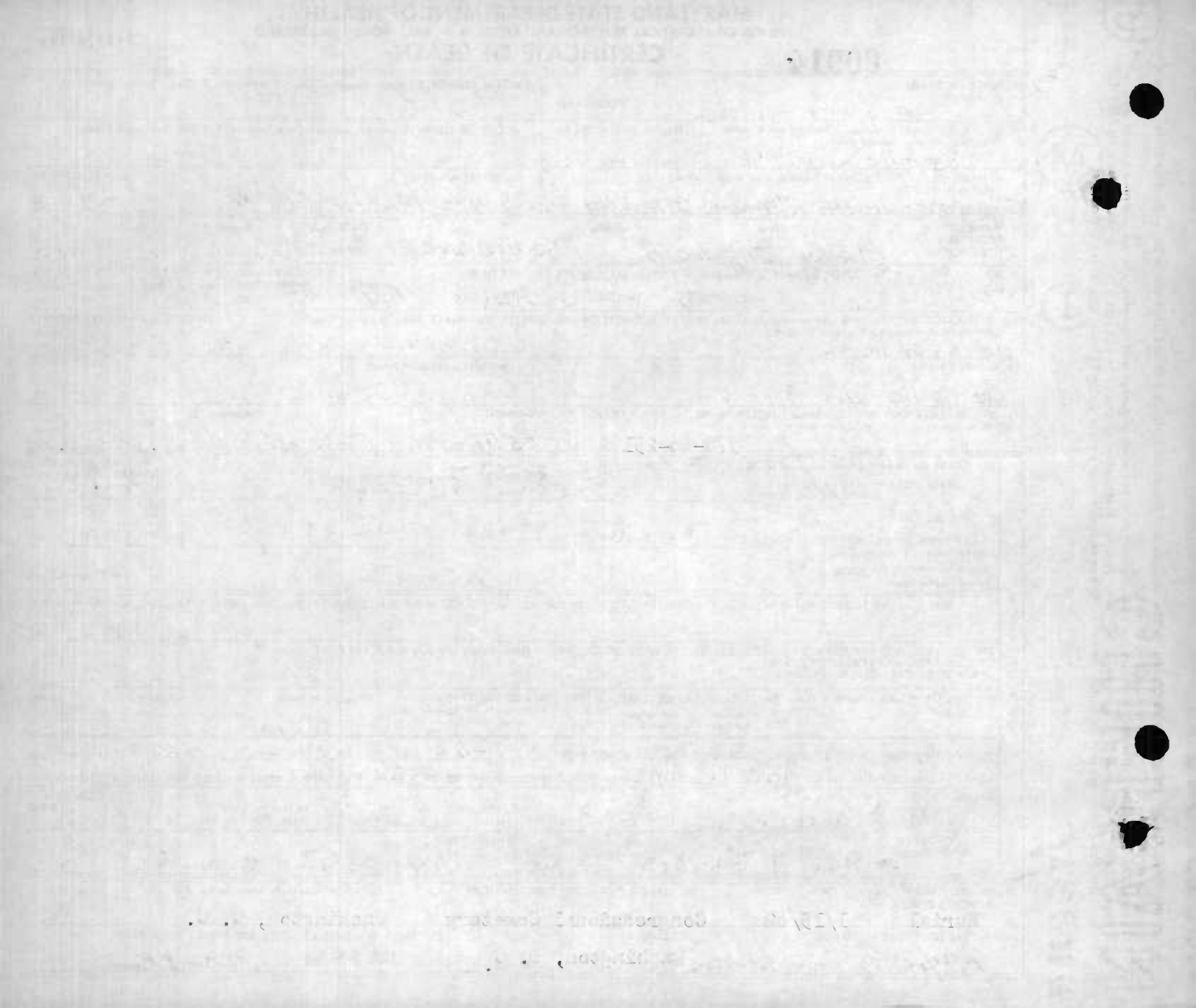
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00906

00914

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>		c. LENGTH OF STAY IN 1b <u>1 yr, 10 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>CONGRESSIONAL MANOR SANITARIUM</u>				d. STREET ADDRESS <u>3819 1/2 Woodley Rd. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Elizabeth</u> <u>SCRIBNER</u>				4. DATE OF DEATH Month Day Year <u>JAN</u> <u>12</u> <u>1962</u>			
5. SEX <u>F</u>		6. COLOR OF RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 8 1879</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dress maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George W. Allen</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Poore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>578-46-2519A</u>		17. INFORMANT Address <u>Mrs Thelma Bonini, East Naples Fla.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cerebrovascular Hemorrhage</u> (c) <u>1-1 hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>5 days -</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-1-60</u> 19 <u>60</u> to <u>1-12</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan 11</u> 19 <u>62</u> and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. GANNON Jr. MD</u>				22d. ADDRESS <u>3141-34th St. N. W. Wash D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/15/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birchison</u>				ADDRESS <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00915  
00907

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN b <i>22 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 19</i> d. STREET ADDRESS <i>8619 Flower arc</i> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Silena LE Seek</i>		4. DATE OF DEATH Month Day Year <i>Jan 20 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 18. 61</i>
9. AGE (In years last birthday) <i>2</i> yrs.		10. IF UNDER 1 YEAR Months Days <i>2 5</i>	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Everett R. Seek</i>	
14. MOTHER'S MAIDEN NAME <i>Carol M. Ford</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Washington San. &amp; Hospital Record</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.5</i> DUE TO <i>Congenital heart disease</i> Conditions, if any, which gave rise to immediate cause (b) <i>Transpiration of great vessels</i> (a), stating the underlying cause last. DUE TO <i>Congenital heart failure</i> (c) <i>3 vols.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 vols.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 29, 1961</i> , to <i>Jan 20, 1962</i> ; that (I) (we) last saw the deceased alive on <i>Jan 20, 1962</i> , and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Winston E. Cochran MD M.D.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>WINSTON E. COCHRAN</i>		22d. ADDRESS <i>800 Residing Drive Silver Spring</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1/23/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Washington Memorial</i>	23d. LOCATION (City, town or county) (State) <i>Adelphi Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>JAN 23 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>		25c. ADDRESS <i>254 Carroll St. N.W. Wash. D.C.</i>	

2075244154

2282

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON, MASS.

*[Faint, mostly illegible text, likely a form or certificate, possibly containing names and dates.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER NOTIFIED AND WILL APPROVE

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
00916					00908					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont. Co.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>42 Kensington</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bethesda Hospital</i>					d. STREET ADDRESS <i>13824 Warner St.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>He</i> Last <i>Feiders</i>					4. DATE OF DEATH Month <i>Jan</i> Day <i>7</i> Year <i>1962</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 15, 1879</i>		9. AGE (In years last birthday) <i>84</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>grocer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Wm. Hamby Feiders</i>					14. MOTHER'S MAIDEN NAME <i>Jessie L. Hixon</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Regina Id. W. Feiders</i>		Address <i>same as above</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>1-6</i> <i>1962</i> to <i>1-7</i> <i>1962</i> that (I) (we) last saw the deceased alive on <i>1-7</i> <i>1962</i> and that death occurred at <i>5:30 PM</i> from the causes and on the date stated above.										
22a. SIGNATURE <i>Sarah E. Glover</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/7/62</i>			
22c. PHYSICIAN'S NAME (Type) <i>SARAH E. GLOVER</i>					22d. ADDRESS <i>10128 Cedar Lane, Kensington, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit</i>		23b. DATE THEREOF <i>1-8-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Green Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Spring Green, Wisconsin</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>					ADDRESS <i>Bethesda, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 9 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hixon</i>	

(M)

00018

CERTIFICATE OF DEATH

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

NOT TO BE REPRODUCED WITHOUT THE WRITTEN PERMISSION OF THE BUREAU OF VITAL RECORDS

X

DATE - 1-1-02  
PLACE -  
NAME -  
AGE -  
SEX -  
RACE -  
OCCUPATION -  
CAUSE OF DEATH -  
SIGNATURE -  
WITNESSES -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. Page 2 may be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN <b>53 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Maryland</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1717 Poplar Lane NW</b> d. STREET ADDRESS <b>47X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>George Leonard Shane</b>			4. DATE OF DEATH <b>January 1, 1962</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>Caucasian</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>December 18, 1903</b>			9. AGE (In years last birthday) <b>58 yrs.</b>			10. IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Naval Officer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George L. Shane</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Welch</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>WIFE: Mrs. Eva D. Shane, Same as #2</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Insufficiency</b> DUE TO (b) <b>Metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>6 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <b>Cirrhosis of Liver</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 8, 1961</b> to <b>Jan. 1, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 1, 1962</b> , and that death occurred at <b>4:17 PM</b> on the causes and on the date stated above.											
22a. SIGNATURE <b>William P. Baker</b> M.D.			22b. DATE SIGNED <b>January 2, 1962</b>			22c. PHYSICIAN'S NAME (Type) <b>WILLIAM P. BAKER, LT MC USN</b>			22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan. 4, 1962</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers Sons Inc.</b> ADDRESS <b>1756 Penn. Ave. NW, WDC</b>			25a. REC'D BY REGISTRAR <b>JAN 3 '62</b> DATE			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

00011

MONTEVIDEO



WASHINGTON

23 days

1945 (1944)

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

1945

1945

December 18, 1945

1945

USA

New York

Received Naval Officer

Washington, D.C.

George H. Brown

Wife: Mrs. Mrs. H. Brown, Same as 1945

Yes

1945

1945

1945

1945

1945

1945

1945

1945

U.S. Naval Hospital, Bethesda, Md.

Washington, D.C.

Washington, D.C.

1945

Joseph Gault's Sons Inc., Type Foundry, Inc.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00918 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00910

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>															
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY in lb <b>20 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Chevy Chase</b>		d. STREET ADDRESS <b>Shepherd</b> <b>3404 Shepherd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Mead</b> Last <b>Sherman</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>16</b> Year <b>1962</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 15, 1900</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired store manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Safeway chain</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles Thatcher Sherman</b>						14. MOTHER'S MAIDEN NAME <b>Jeanette G. Cropp</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-05-1674</b>				17. INFORMANT <b>Mrs. Christine E. Sherman Item #2</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous coronary disease</b>												INTERVAL BETWEEN FOUND AND DEATH <b>in bed</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		Month, Day, Year <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1-16-62</b> Address (Street, city, town, or county)																			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										22b. DATE THEREOF <b>1-18-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Prince Georges Maryland</b>	
23. FUNERAL DIRECTOR <b>R. A. Ziska</b> <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 19 '62</b>				24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>											





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00911

00919

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,314 Armory Ave.</b>		d. STREET ADDRESS <b>10,314 Armory Ave.</b>	

3. NAME OF DECEASED (Type or print) First <b>Arad</b> Middle <b>Benjamin</b> Last <b>Shipp</b>			4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1898</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Reserve System</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
13. FATHER'S NAME <b>Benjamin Shipp</b>			14. MOTHER'S MAIDEN NAME <b>Mary Turpin</b>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Lola A. Shipp</b>	
				Address <b>10,314 Armory Ave. Kensington Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion (IHD)</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>yr</b>		INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	

21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> to <b>Jan 4</b> 1962, that (I) (we) last saw the deceased alive on <b>Jan 6</b> 1962, and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Samuel Allen, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/7/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL ALLEN, M.D.</b> <b>Kensington Maryland</b>		22d. ADDRESS <b>10,407 Fawcett St. Kensington, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-9-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>	25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10019

CERTIFICATE OF DEATH

AMERICAN AND FOREIGN ASSURANCE CO. OF NEW YORK

*[Faint, mostly illegible text and lines on a form, likely a death certificate. The text is mirrored and difficult to decipher.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00920

00912

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>8 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>Box 264</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ROGER</b> Last <b>SHOEMAKER</b>		4. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-86</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>nursery</b>	
10a. FATHER'S NAME <b>William Shoemaker</b>		10b. MOTHER'S MAIDEN NAME <b>Betty Myers</b>	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		12. SOCIAL SECURITY NO. <b>215-18-0136</b>	
13. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILE PERITONITIS</b> <b>588</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RUPTURED GALL BLADDER</b> <b>XXXX</b> (c) <b>BILATERAL BRONCHOPNEUMONIA</b>		14. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
15. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
17. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 8, 1962</b> , to <b>9:52P</b> , that (I) (we) last saw the deceased alive on <b>JAN. 8, 1962</b> , and that death occurred at <b>10:00M</b> , from the causes and on the date stated above.		22. SIGNATURE <b>Arthur F. Woodward</b> M.D. <b>ARTHUR F. WOODWARD, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-12-62</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
26. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>		27. LOCATION (City, town or county) (State) <b>Laytonsville, Md.</b>	
28. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		29. DATE <b>JAN 15 '62</b>	

(M)

(I)

00029

CLASSIFICATION OF DATA

CONFIDENTIAL

ANYTHING

LOCKVILLE

A. H. H.

ANY

Box 244

CONFIDENTIAL GENERAL HOSPITAL

BROWNMAN

ROGER

CHARLES

2-14-86

White

Male

Virginia

Henry

Labored

Betty Hynes

William Shoemaker

Hospital records

21-18-0120

Unknown

BILE POSITIONING

REPTURED GALL BLADDER

BILATERAL BRONCHOPNEUMONIA

JAN. 8 1952

02

JAN. 8

ROCKVILLE, MARYLAND

ARMED & DANGEROUS, U.S.

Washington, D.C.

Lawrenceville

1-12-52

Ensign

JAN 15 1952

Lawrenceville, Ga.

Francis H. H. 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1-B  
00921  
00913  
M 74  
I  
2  
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>Thrs. Home</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>13014 - Atlantic Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucille A. M. Sievers</u>		4. DATE OF DEATH <u>Jan. 22 1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/1942</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen L. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Strier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>536-07-6395</u> John R. Sievers-Husanbd-same 2d	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept - 1961</u> to <u>Jan 22, 1962</u> that (I) <u>was</u> last saw the deceased alive on <u>27 Jan 1962</u> and that death occurred at <u>10:40 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Brunton</u> M.D.		22b. DATE SIGNED <u>Jan 22 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Brunton</u>		22d. ADDRESS <u>4743 Bradley Blvd. Uthrs, md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>1/25/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

1900

M

John H. Jones - 1900

20th - 1900

James W. Harrison  
Horace W. Harrison

Robert A. Humphrey, Secretary, Maryland  
Oscar Hill, Secretary, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00922  
011914  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Charles Town</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Route #1</b>	
3. NAME OF DECEASED (Type or print) First <b>Annette</b> Middle <b>Gay</b> Last <b>Silveous</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1961</b>
9. AGE (In years last birthday) <b>9</b> yrs. <b>2</b> Months <b>2</b> Days		IF UNDER 1 YEAR Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Silveous</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Bagent</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure, ascites, anemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Thrombocytopenia, heart failure</b> (c) <b>Disseminated Histoplasmosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>134.2</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 month</b> <b>2 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 12, 1961</b> to <b>January 2, 1962</b> that (I) (we) last saw the deceased alive on <b>January 2, 1962</b> , and that death occurred at <b>4:10 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard Adler, M.D.</i> M.D.		22b. DATE SIGNED <b>1/3/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD ADLER, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/5/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Quaker Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Winchester, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 4 '62</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur E. Hume</i>			

9VVVVVVV 85V

22

00923

## CERTIFICATE OF DEATH

Reg. Dist. No.

00915

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>59 Bethesda. Ind.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6533 ELGIN LANE</b>		d. STREET ADDRESS <b>6533 Elgin Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>SILVER</b> Last <b>SILVER</b>		4. DATE OF DEATH Month <b>1</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15, 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	IF UNDER 24 HRS. Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DAVID EISENBERG</b>		14. MOTHER'S MAIDEN NAME <b>DIANA STEINBERG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>JACK SILVER</b>		Address <b>BETH. MD.</b> <b>6533 ELGIN LANE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO <b>Coronary Arterio-sclerotic Heart Disease</b> (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>62 Days</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 4, 1961</b> , to <b>Jan 5, 1962</b> , that I last saw the deceased alive on <b>Jan 3, 1962</b> , and that death occurred at <b>5:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William S. Miller</b> M.D.		ADDRESS (Street, city or town, state) <b>1835 EYE ST N.W.</b> DATE SIGNED <b>WASH. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>William S. Miller M.D.</b>		<b>WASH. D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-7-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY + SONS - 3501-14th ST. NW</b>		24a. REC'D BY REGISTRAR <b>JAN 9 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923



STREET AND NUMBER 1003 E. EIGHTH ST.		CITY BALTIMORE	
NAME OF DECEASED DANIEL EISENBERG		SEX MALE	
DATE OF BIRTH MAY 12 1898		PLACE OF BIRTH RUSSIA	
OCCUPATION STEINBERG		CAUSE OF DEATH TUBERCULOSIS	
DATE OF DEATH MAY 12 1923		PLACE OF DEATH BALTIMORE	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF NEXT OF KIN [Signature]	
SIGNATURE OF BURIAL OFFICIAL [Signature]		SIGNATURE OF REGISTRAR [Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00924  
CERTIFICATE OF DEATH  
00916

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmor Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda,</b> d. STREET ADDRESS <b>7600 Hemlock St., Bethesda</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Hannah M. Skerritt</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>7</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1877</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Skerritt</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Williams</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Jane L. Seaman</b> Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal bleeding, abd. tumor, cholesterol</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>23 9 X</b> (c) <b>48 hours</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Bethesda</b>		20g. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 9, 1960</b> to <b>Jan 6, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 6, 1962</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Herbert Martin Jr</b> M.D.		22b. DATE SIGNED <b>Jan 6, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>HERBERT MARTIN JR</b>		22d. ADDRESS <b>5029 Bethesda Ave Bethesda Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 10, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenfield Cem.,</b>
23d. LOCATION (City, town or county) <b>Hempstead, New York</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> ADDRESS <b>Bethesda 14, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>			

(M)

(1)

*Entered this book, and turned the pages*

*Robert M. ...*  
*HEBERT MARVIN 2022 ...*  
*...*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00925

CERTIFICATE OF DEATH

Reg. Dist. No. 00917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Kensington Md</u> c. LENGTH OF STAY IN 1b <u>1 year</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanatorium Kensington Md</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>5429 Conn. Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>G</u> Middle <u>Mabel</u> Last <u>Slattey</u> 4. DATE OF DEATH <u>1-15-62</u> Month <u>Jan</u> Day <u>Monday</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7/1/84</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>USA Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gates Frank</u>		14. MOTHER'S MAIDEN NAME <u>Wilburger Amanda</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-01-9646A</u> INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, LOBAR, RT LOWER LOBE</u> DUE TO <u>490X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 DAYS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBROVASCULAR ACCIDENT</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT.</u> , 19 <u>59</u> , to <u>JAN. 15</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>JAN 15</u> , 19 <u>62</u> , and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen W. Dwyer</u> M.D.		ADDRESS (Street, city or town, state) <u>6719 WILSON LANE</u> DATE SIGNED <u>BETHESDA 14, MD.</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN W. DWYER, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/18/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>2801-14th St. N.W. was h. 9, D.C.</u>		24a. RECORDING REGISTRAR'S SIGNATURE <u>JAN 17 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

10082

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF BIRTH

CAUSE OF DEATH

PLACE OF DEATH

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

REGISTRATION NUMBER

OFFICIAL SEAL

OFFICIAL SIGNATURE

CERTIFICATE OF DEATH

Reg. Dist. No. 00918

00926

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9401 New Hampshire Ave.</u>		d. STREET ADDRESS <u>19401 New Hampshire Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Elizabeth Smart</u>		4. DATE OF DEATH Month Day Year <u>Jan. 28 1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1872</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Hammen</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Simonsen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Stanley N. Smart</u> Address <u>9401 New Hampshire Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>131X</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1957</u> to <u>Jan. 28, 1962</u> , that I last saw the deceased alive on <u>Jan. 27, 1962</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Kaubach</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1806 Fox St. 1/28/62</u>	
PHYSICIAN'S NAME (Type) <u>James L. Kaubach</u>		<u>Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-30-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 31 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

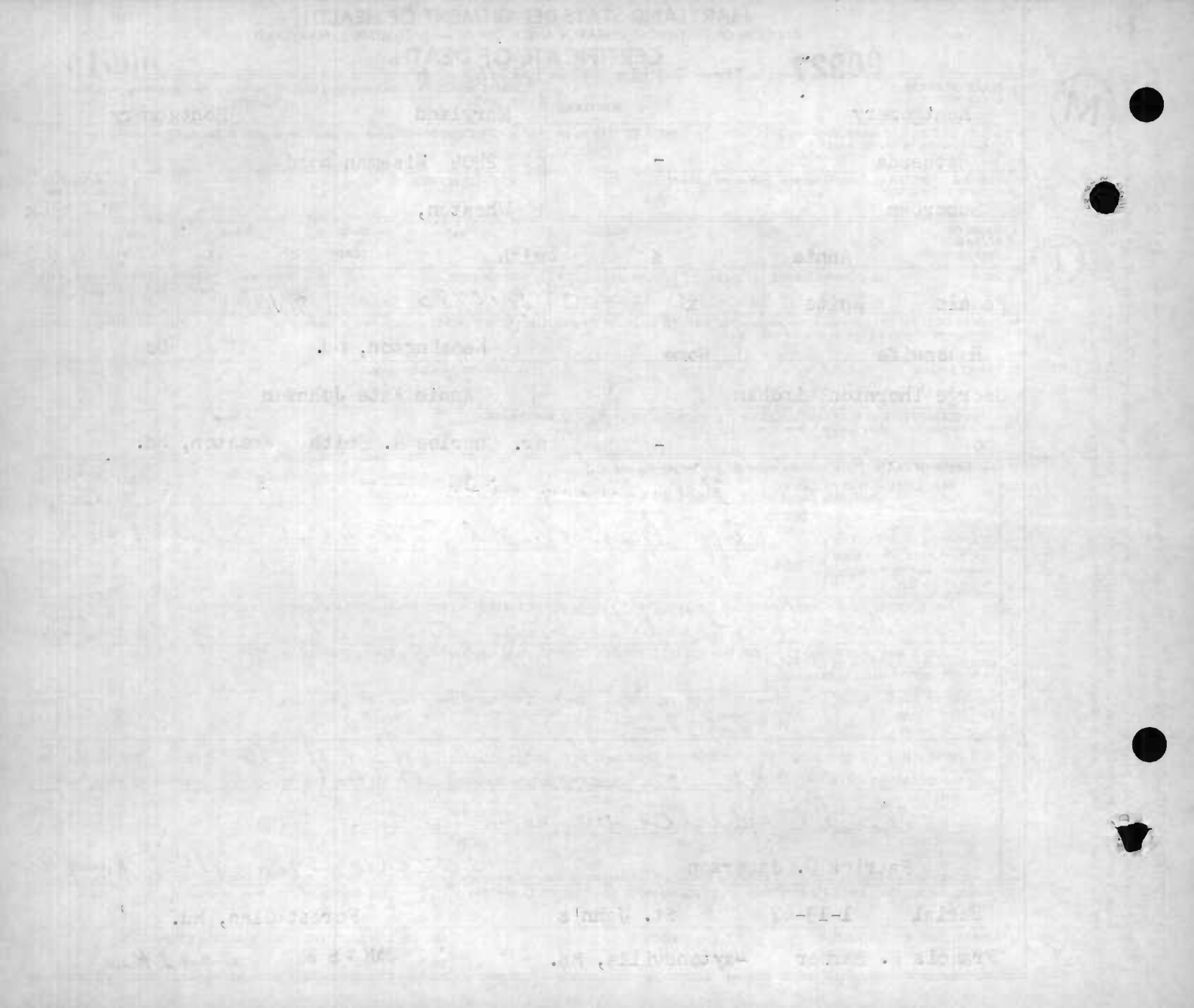
CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH BALTIMORE, MD		5. OCCUPATION Carpenter		6. MARITAL STATUS Married	
7. DATE OF DEATH Jan 15 1900		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. PERMANENT Yes	
13. INTERMENT Catholic Cemetery		14. GRAVE Lot 10		15. SIGNATURE OF REGISTRAR J. H. Harris	
16. SIGNATURE OF DECEASED J. H. Harris		17. SIGNATURE OF WITNESSES J. H. Harris		18. SIGNATURE OF PHYSICIAN J. H. Harris	
19. SIGNATURE OF CLERK J. H. Harris		20. SIGNATURE OF JURY J. H. Harris		21. SIGNATURE OF JUDGE J. H. Harris	
22. SIGNATURE OF SHERIFF J. H. Harris		23. SIGNATURE OF CONSTABLE J. H. Harris		24. SIGNATURE OF TOWNSHIP CLERK J. H. Harris	
25. SIGNATURE OF COUNTY CLERK J. H. Harris		26. SIGNATURE OF STATE CLERK J. H. Harris		27. SIGNATURE OF U.S. MARSHAL J. H. Harris	
28. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		29. SIGNATURE OF U.S. ATTORNEY J. H. Harris		30. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
31. SIGNATURE OF U.S. SHERIFF J. H. Harris		32. SIGNATURE OF U.S. CONSTABLE J. H. Harris		33. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
34. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		35. SIGNATURE OF U.S. STATE CLERK J. H. Harris		36. SIGNATURE OF U.S. MARSHAL J. H. Harris	
37. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		38. SIGNATURE OF U.S. ATTORNEY J. H. Harris		39. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
40. SIGNATURE OF U.S. SHERIFF J. H. Harris		41. SIGNATURE OF U.S. CONSTABLE J. H. Harris		42. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
43. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		44. SIGNATURE OF U.S. STATE CLERK J. H. Harris		45. SIGNATURE OF U.S. MARSHAL J. H. Harris	
46. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		47. SIGNATURE OF U.S. ATTORNEY J. H. Harris		48. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
49. SIGNATURE OF U.S. SHERIFF J. H. Harris		50. SIGNATURE OF U.S. CONSTABLE J. H. Harris		51. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
52. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		53. SIGNATURE OF U.S. STATE CLERK J. H. Harris		54. SIGNATURE OF U.S. MARSHAL J. H. Harris	
55. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		56. SIGNATURE OF U.S. ATTORNEY J. H. Harris		57. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
58. SIGNATURE OF U.S. SHERIFF J. H. Harris		59. SIGNATURE OF U.S. CONSTABLE J. H. Harris		60. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
61. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		62. SIGNATURE OF U.S. STATE CLERK J. H. Harris		63. SIGNATURE OF U.S. MARSHAL J. H. Harris	
64. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		65. SIGNATURE OF U.S. ATTORNEY J. H. Harris		66. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
67. SIGNATURE OF U.S. SHERIFF J. H. Harris		68. SIGNATURE OF U.S. CONSTABLE J. H. Harris		69. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
70. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		71. SIGNATURE OF U.S. STATE CLERK J. H. Harris		72. SIGNATURE OF U.S. MARSHAL J. H. Harris	
73. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		74. SIGNATURE OF U.S. ATTORNEY J. H. Harris		75. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
76. SIGNATURE OF U.S. SHERIFF J. H. Harris		77. SIGNATURE OF U.S. CONSTABLE J. H. Harris		78. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
79. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		80. SIGNATURE OF U.S. STATE CLERK J. H. Harris		81. SIGNATURE OF U.S. MARSHAL J. H. Harris	
82. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		83. SIGNATURE OF U.S. ATTORNEY J. H. Harris		84. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
85. SIGNATURE OF U.S. SHERIFF J. H. Harris		86. SIGNATURE OF U.S. CONSTABLE J. H. Harris		87. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
88. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		89. SIGNATURE OF U.S. STATE CLERK J. H. Harris		90. SIGNATURE OF U.S. MARSHAL J. H. Harris	
91. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		92. SIGNATURE OF U.S. ATTORNEY J. H. Harris		93. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	
94. SIGNATURE OF U.S. SHERIFF J. H. Harris		95. SIGNATURE OF U.S. CONSTABLE J. H. Harris		96. SIGNATURE OF U.S. TOWNSHIP CLERK J. H. Harris	
97. SIGNATURE OF U.S. COUNTY CLERK J. H. Harris		98. SIGNATURE OF U.S. STATE CLERK J. H. Harris		99. SIGNATURE OF U.S. MARSHAL J. H. Harris	
100. SIGNATURE OF U.S. DISTRICT JUDGE J. H. Harris		101. SIGNATURE OF U.S. ATTORNEY J. H. Harris		102. SIGNATURE OF U.S. DEPUTY ATTORNEY J. H. Harris	

RECEIVED  
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BALTIMORE, MD







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00928

CERTIFICATE OF DEATH

00920

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>18 1/2 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Rockville</b>		d. STREET ADDRESS <b>1 5602 Randolph Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Montgomery Bradford Smith</b>		4. DATE OF DEATH <b>January 11, 1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 2, 1876/1867</b>		9. AGE (In years last birthday) <b>94 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Agustus W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Henritta Handy</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Eugene Stubbs-Nephew-same 2d</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420 coronary + thrombosis</b> DUE TO (b) <b>arteriosclerosis &amp; old age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>fell down stairs - 3 broken ribs</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12/22/61</b> 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring Md 44</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>9/15/15</b> to <b>Jan 11, 62</b> , 19... that (I) (we) last saw the deceased alive on <b>1/10/62</b> 19... and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Patrick C. Jameson</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/11/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Patrick C. Jameson</b>		22d. ADDRESS <b>12020 Georgia Silver Spring Md</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/13/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Forest Glen, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b> c. LENGTH OF STAY IN 1b <b>10/25/61-1-4-62</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FAIRLAND NURSING HOME</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT COLUMBIA</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>4201-MASS. AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>			First <b>F</b>			Middle <b>S</b>			Last <b>SMITH</b>			4. DATE OF DEATH Month <b>1-</b> Day <b>4</b> Year <b>1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB 26-1881</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>				11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>FREDERICK SMITH</b>						14. MOTHER'S MAIDEN NAME <b>JOSEPHINE DICKERSON</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES-Spanish-Amer.</b>				16. SOCIAL SECURITY NO. <b>1-25-</b>				17. INFORMANT <b>Address</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) <b>Generalized atherosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 29, 1961</b> to <b>JAN 4, 1962</b> that (I) (we) last saw the deceased alive on <b>JANUARY 4, 1962</b> and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>BORIS RABKIN</b>						M.D. <b>ATTENDING PHYS. <input checked="" type="checkbox"/></b>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>BORIS RABKIN, M.D.</b>						22d. ADDRESS <b>1019 UNIVERSITY BLVD EAST SILVER SPRING MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>1-9-62</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT. CEM.</b>			23d. LOCATION (City, town or county) (State) <b>ARLINGTON, VIRGINIA</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>DEAL FUNERAL HOME 4812 GA. AVE. N.W. WASHINGTON DC</b>						ADDRESS			25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

60325

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00930

00922

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Comus</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Comus</b>	
c. LENGTH OF STAY IN 1b <b>14 yrs.</b>		d. STREET ADDRESS <b>-----</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Ruth</b> Last <b>Spates</b>		4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/21/1912</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b> Hours <b>1</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James E. Fox</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Bell Suddath</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-6559</b>	
17. INFORMANT <b>George E. Spates</b>		Address <b>Comus, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b> <b>4 YEARS</b> <b>5 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/1/30</b> , 19 <b>49</b> , to <b>1/29</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/31</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James P. Kerr</b>		22b. DATE SIGNED <b>1/29/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>James. P. Kerr</b>		22d. ADDRESS <b>DAMASCUS, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		23d. LOCATION (City, town or county) (State) <b>Beallsville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		25a. REC'D BY REGISTRAR <b>FEB 2 '62</b>	
ADDRESS <b>Barnesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



Montgomery

Montgomery

Montgomery

Conus

14 yrs.

Conus

Jocelyn

Birth

Spencer

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22

62

Female White

1/21/1912

20

Nonsexable

Washington, D.C.

James E. Fox

Birth Bell Substation

211-24-2227

George A. Spencer

Conus, Md.

James P. Acker

Monocacy

Heathsville

Md.

Barnesville, Md.



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00931

00923

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Spencerville</b> g. STREET ADDRESS <b>X</b> h. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Osborn</b> Middle <b>N</b> Last <b>Stabler</b>		4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/1901</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farmer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>United States</b>	
13. FATHER'S NAME <b>Newton Stabler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hallowell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>220 34 7932</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding peptic ulcer, stomach.</b> Conditions, if any, which gave rise to immediate cause (b) <b>Portal vein thrombosis</b> (c) <b>Primary Carcinoma of liver</b> cause last, <b>155.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>2 wks</b> <b>8 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 8, 1961</b> to <b>1/17/62</b> that (I) (we) last saw the deceased alive on <b>1/17/62</b> and that death occurred at <b>11:17</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Ligon</b>		22b. DATE SIGNED <b>1/18/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M.D.</b>		22d. ADDRESS <b>SANDY SPRINGS, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 19 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friends</b>		23d. LOCATION (City, town or county) (State) <b>Sandy Spring Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>JAN 22 1962</b>	
ADDRESS <b>Laytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

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Item 10 Filed 304 2-9-62

00932

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

00924

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Silver Springs</u>			
c. LENGTH OF STAY IN 1b <u>1 DAY</u>				d. STREET ADDRESS <u>12814 Valleywood Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Anne Stambaugh</u>				4. DATE OF DEATH Month Day Year <u>Jan. 16 1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-59</u>	9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas H. Stambaugh</u>				14. MOTHER'S MAIDEN NAME <u>Frances Stephenson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Pt. chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>viral infection</u> 096.9 DUE TO <u>Overwhelming toxemia due to (a)</u> Conditions, if any, which gave rise to immediate cause (b) } (e), stating the underlying cause last. } DUE TO (c) <u>mental retardation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>mental retardation</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> to <u>1/16</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>62</u> , and that death occurred at <u>10:51</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert H Diamond</u>				22b. DATE SIGNED <u>1/17/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>H.H. DIAMOND</u>				22d. ADDRESS <u>911-SILVER SPRING AVE S.S. MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Virginia</u>		23d. LOCATION (City, town or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recorded by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00933 Item 9, film G306 2/2/62 iwk 00925											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. LENGTH OF STAY in 1b <i>1 yr 11 mths +</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jokma Park</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Kensington Gardens Sanitarium</i>				d. STREET ADDRESS <i>7101 Holly Avenue</i>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>ERNEST CRAVATH STEWARD</i>				DATE OF DEATH Month Day Year <i>Jan 28 1962</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 2, 1871</i>		9. AGE (In years, last birthday) <i>90 9 11</i> yrs.		IF UNDER 1 YEAR Months Days <i>9 11</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Chattanooga, Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
13. FATHER'S NAME <i>Thomas C. Steward</i>				14. MOTHER'S MAIDEN NAME <i>Lydia Farmer</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>yes W.W.I</i>				16. SOCIAL SECURITY NO. <i>579-32 4903A</i>				17. INFORMANT Address <i>Mrs. Luther C. Steward, 2210 F.N. Rd. D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>450.0</i> DUE TO <i>Senile Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>10 yrs</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>1942</i> to <i>28 Jan 1962</i> , that (I) (we) last saw the deceased alive on <i>25 Jan 1962</i> , and that death occurred at <i>9:25 PM</i> , from the causes and on the date stated above.											
22e. SIGNATURE <i>H.B. Queen</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>28 Jan 1962</i>			
22c. PHYSICIAN'S NAME (Type) <i>H.B. QUEEN</i>				22d. ADDRESS <i>7112 Willow Ave TAKOMA PARK, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 31, 1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Arlington Virginia</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walton, 254 Carroll N.W. D.C.</i>				25. REC'D BY REGISTRAR DATE <i>JAN 30 '62</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DEPARTMENT OF HEALTH DIVISION OF STATISTICS AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
00934						00926											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Annandale c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X-3 d. STREET ADDRESS 910 Bruce Lane											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Doris Marie Stover						4. DATE OF DEATH Month Day Year January 21 19 62											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 June 1927		9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Leo Montgomery						14. MOTHER'S MAIDEN NAME Violet Nutwell											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Husband Donald L. Stover Same as #2 Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary insufficiency DUE TO pleural + pericardial metastases Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO carcinoma of the breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos 20 mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 January, 1962, to 21 January, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 January, 1962, and that death occurred at 1620 PM on the causes and on the date stated above.																	
22a. SIGNATURE Barclay M. Shepard 22a. PHYSICIAN'S NAME (Type) BARCLAY M. SHEPARD LT MC USN						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> Jan. 22, 1962 22b. DATE SIGNED											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-24-62		23c. NAME OF CEMETERY OR CREMATORY St. Marys' Church Cemetery Bryontown, Maryland				23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE HUNT Funeral Home, Waldorf, Maryland						25a. REC'D BY REGISTRAR DATE 23 '62		25b. REGISTRAR'S SIGNATURE C. L. Thomas									

00284



100-10000 (100-1)

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U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00935

00927

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4717 N. Chelsea Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Merle LaRue Sweet</b>			4. DATE OF DEATH <b>January 3, 1962</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Caucasian</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Aug. 4, 1885</b>		
9. AGE (In years last birthday) <b>76</b> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Administration</b>			11b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Gaines Sweet</b>			14. MOTHER'S MAIDEN NAME <b>Rose Bell Hurlbut</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Sis: Miss Harriett Ann Sweet, Washington, D.C.</b>			Address <b>4801 Conn. Ave. NW</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MITRAL AND AORTIC VALVULITIS</b> <b>410X</b> DUE TO <b>RHEUMATIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>BRONCHOPNEUMONIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
21a. TIME OF INJURY Hour e.m. p.m. <b>19</b>			21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			21d. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Brosch</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>FRANK J. Brosch</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>1-3-62</b>		
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			22b. DATE THEREOF <b>1-5-62</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			22d. LOCATION (City, town, or country) (State) <b>Suitland, Md.</b>		
23. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>			24a. REC'D BY REGISTRAR <b>JAN 8 '62</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>					

00233



Boatman (Rural)

U. S. Navy Hospital

Aug. 1, 1933

12-12

Administration

Penitentiary

William O. Smith

House Bill Number

House Bill Number 10000, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00936

00928

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN b. <b>53 days</b>		d. STREET ADDRESS <b>Mundata Hotel 20th &amp; Kalorama</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SURBURBAN HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>B.</b> Last <b>SWIGETT</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/20/1866</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		9b. AGE (In years last birthday) <b>95</b> yrs. IF UNDER 1 YEAR: Months <b>2</b> Days <b>19</b> Hours <b>62</b> Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>INDIANA</b>	
13. FATHER'S NAME <b>JOHN BAIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. MOTHER'S MAIDEN NAME <b>BETHSHEBA GOSS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>KIVETT, MARTINSVILLE, IND.</b>	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO <b>(Possible pulmonary embolism)</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Fracture of rt. hip, 9th 1961 when she fell at home</b> (c) <b>At fall at home &amp; fractured hip.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Fracture of rt. hip, 9th 1961 when she fell at home</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>9th 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Wash</b> (County) <b>DC.</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> to <b>2 Jan 1962</b> that (I) (we) last saw the deceased alive on <b>1 Jan 1961</b> , and that death occurred at <b>T.H.M.A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry A. Horstman, Jr.</b> M.D.		22b. DATE SIGNED <b>2 Jan 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>HARRY A. HORSTMAN</b>		22d. ADDRESS <b>1835 EYE ST., N.W., WASH., D.C.</b>	
23a. (BURIAL) CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JAN 3, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SOUTH PARK CEMETERY</b>	23d. LOCATION (City, town or county) <b>MARTINSVILLE, INDIANA</b> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons</b> ADDRESS <b>1756 PA. AVE N.W.</b>		25a. REC'D BY REGISTRAR <b>JAN 4 '62</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

00033E

SURBURN HOSPITAL

SWIGETT

B.

EMMA

RECEIVED

1911 JAN

(Personal of Emma Swigett)

Received of Mr. J. H. Swigett the sum of £100.00

for the sum of £100.00

1911 JAN 10

W. A. HARRISON



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00937 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00929

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>mnty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY in lb <u>5 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Silver Spring</u>		d. STREET ADDRESS <u>4509 Beunton Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>105 Russell Ave - Dr Schumaker's Office</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>Christine</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-61</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u>2</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>							
13. FATHER'S NAME <u>Joel Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Christine Bogley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Christine Taylor (mother)</u> Address <u>Stuen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>475X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 day.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Jan 24-1962</u> Address (Street, city, town, or county) _____							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 29 '62</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u>	

2073212153



Robert A. Thompson, Secretary, Maryland  
Baltimore, Maryland  
1940

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00930

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md</i> b. COUNTY <i>montg</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Ellettsville</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Spencerville</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Montg General Hosp</i>			d. STREET ADDRESS <i>md R-198</i>		
3. NAME OF DECEASED (Type or print) <i>Mary Ellen Thomas</i>			4. DATE OF DEATH <i>Jan 2 1962</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1880 8/1</i>		9. AGE (in years last birthday) <i>81</i> yrs.
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>
13. FATHER'S NAME <i>Jack Sayles</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Archie Thomas (Son)</i> Address <i>Stem 2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Chronic valvular heart disease + hypertension</i> (c) <i>year</i>					INTERVAL BETWEEN ONSET AND DEATH <i>year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschalt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>1-2-61</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschalt</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/7/62</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. James Baptist..</i>		22d. LOCATION (City, town, or country) (State) <i>Bealeton, Va.</i>	
23. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 11 '62</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

MEDICAL CERTIFICATION

M

00938

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1930

1930

1930

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00931

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

(M)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>4 mo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>24 E. Montgomery Ave - apt X</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>09</u>			
f. STREET ADDRESS <u>24 E Montg. Ave apt X</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cherry Lee Tonker</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-31-17</u>	
9. AGE (in years last birthday) <u>44</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>230-285083</u>			
17. INFORMANT <u>Martin Tonker</u>				Address <u>Itan 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart failure</u> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Valvular Heart disease</u> DUE TO (c) <u>sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCAW</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-12-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/16/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	
22d. LOCATION (City, town, or country) (State) <u>Gaithersburg, Md.</u>							
23. FUNERAL DIRECTOR <u>Guyon Wheeler Funeral Home</u> <u>1331 E. Montg. Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 17 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00940

Item 6 Film G306 2/5/62 iwk

CERTIFICATE OF DEATH

00932

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>BEL PRE Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington DC.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>1614 Good Hope Rd S.E.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAULINE</b> First <b>WAGLE</b> Middle <b>TROOP</b> Last 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Latvia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		4. DATE OF DEATH <b>1/30/62</b> Month <b>1</b> Day <b>30</b> Year <b>1962</b> 8. DATE OF BIRTH <b>4-20-1888</b> 9. AGE (In years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <b>Unknown.</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>NONE</b> 17. INFORMANT <b>O. Benjamin Troop, 1614 Good Hope Rd S.E. DC.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of The Stomach</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (b) <b>8 months</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dehydration, Decubitus ulcers</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <b>1/29/62</b> Hour <b>9</b> a.m. <b>17</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that (I) (this hospital) attended the deceased from <b>1/5/62</b> to <b>1/30/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/29/62</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Max G. Sherer</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>MAX G. SHERER MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1/30/62</b> 22d. ADDRESS <b>2025 EAST West H'way Silver Spring Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>1/31/1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>S.E. HEBREW Cem.</b> 23d. LOCATION (City, town or county) (State) <b>WASH. DC</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Hallberg Funeral Home</b> ADDRESS <b>4217-9th St. N.W.</b> 25a. REC'D BY REGISTRAR <b>JAN 31 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Wm. S. Pinner</b>	

(M)

(S)

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Mr. [unclear]

21. [unclear]

As per [unclear]

[unclear]

[unclear]

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[unclear]

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Center of the [unclear]

Information, [unclear]

Mr. [unclear]

Mr. C. [unclear]

[unclear]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00941

00933

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>133 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1354 Somerset Place, N.E.</b> d. STREET ADDRESS <b>47X-3</b>	
3. NAME OF DECEASED (Type or print) <b>Owen Austin Troy</b>		4. DATE OF DEATH <b>January 18, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 3, 1899</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		12. BIRTHPLACE (County & State, or foreign country) <b>California</b>	
13. FATHER'S NAME <b>Theodore W. Troy</b>		14. MOTHER'S MAIDEN NAME <b>Juliette Washington</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic pneumonitis</b> 203 X DUE TO <b>Multiple myeloma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>8 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 7, 1961</b> to <b>January 18, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 18, 1962</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.		26. SIGNATURE <b>Geo. H. Porter III MD</b>	
27. PHYSICIAN'S NAME (Type) <b>George H. Porter III, MD</b>		28. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
29. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		30. DATE THEREOF <b>1/22/62</b>	
31. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		32. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
33. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Plummer</b>		34. ADDRESS <b>3015 12th St. N. E.</b>	
35. REC'D BY REGISTRAR <b>JAN 22 '62</b>		36. REGISTRAR'S SIGNATURE <b>John S. Frank</b>	

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Director of Columbia

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199 days

Between

1991 January 1, 1991

The Clinical Center, Bethesda, Md.

1991 January 1, 1991

Between

November 1, 1991

Between

1991 January 1, 1991

Between

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>28 Silver Spring</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2114 Seminary Rd</b>				d. STREET ADDRESS <b>2114 Seminary Rd</b>			
3. NAME OF DECEASED (Type or print) <b>Susie</b>		First <b>Maud</b> Middle <b>Tucker</b> Last <b>Tucker</b>		4. DATE OF DEATH <b>Jan 13 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-8-1886</b>	
9. AGE in years (last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b>		IF UNDER 24 HRS. Hours <b>15</b> Min. <b>30</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N. S. Gov</b>		11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>David Hampton Pugh</b>				14. MOTHER'S MAIDEN NAME <b>Mary Stuart Lewis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Francis P. Mann</b>				Address <b>2408 Seminary Rd Silver Spring md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>153.9</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Carcinoma of lower intestinal tract with metastasis</b> DUE TO <b>metastasis</b> (c) <b>1 1/2 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Bruschert</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BRUSCHERT</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>1-13-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/16/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR <b>The S. H. Hines Company-Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>JAN 15 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hinkle</b>			

MEDICAL CERTIFICATION





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FOR STATE  
HEALTH DEPT.  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00943 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00935

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>18806 Lamer Dr - Apt 104</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Jack Turner</u> First Middle Last				4. DATE OF DEATH <u>Jan 30 1962</u> Month Day Year					
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 10 - 1910</u> Yrs. Months Days		9. AGE (in years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov. RETIRED Claim Dept</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Monette Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Charles Turner</u>				14. MOTHER'S MAIDEN NAME <u>Maudie Csee</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>APR 1942 - NOV 1945</u>				16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>Janet Turner (wife)</u> Address <u>Item 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 322-2-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Aspiration of stomach contents</u> DUE TO (c) <u>Chronic alcoholism</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in chair at home</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead sitting in lounge chair at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>2 Hour a.m. 1-30 1962</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschait</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-30-62</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-1-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or country) <u>Prince George</u> (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR <u>R.A. Ziska</u> ADDRESS <u>8434 Georgia Ave.</u>				24a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>		24b. REGISTRAR'S SIGNATURE <u>Silver Spring, Md.</u>		DATE <u>FEB 2 '62</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be received by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall</u>		d. STREET ADDRESS <u>6111 Western Ave N.W.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>REBECCA</u> Last <u>UMSTEAD</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 18-1886</u>
9. AGE <u>75</u> yrs. last birthday		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>C &amp; P Telephone Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William J. Umstead</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Austin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Anna M. Umstead - sister - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ESSENTIAL HYPERTENSION</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>FEMORAL THROMBOSIS (RIGHT LEG)</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>10</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 22</u> , 19 <u>61</u> , to <u>Jan. 30</u> , 19 <u>62</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Jan. 30</u> , 19 <u>62</u> , and that death occurred at <u>10:10</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Henry M. Lowden</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Jan. 30-1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY M LOWDEN</u>		22d. ADDRESS <u>5206 Norman Dr. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-27-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 6 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinkle</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00945

## CERTIFICATE OF DEATH

00937

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b> <b>31</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>10907 Fiesta Road</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Martyn Kirk Usilaner</b>			4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 17, 1953</b> <b>8</b> yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Hiram Usilaner</b>		
14. MOTHER'S MAIDEN NAME <b>Miriam Millman</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>The Medical Record</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Compression</b> DUE TO 224X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hydrocephalus</b> DUE TO (c) <b>Craniopharyngioma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 year</b> <b>2 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 5, 1962</b> to <b>January 8, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 8, 1962</b> , and that death occurred <b>11:32 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert L. Fisher</b>			22b. DATE SIGNED <b>January 9, 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>Robert L. Fisher</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-10-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden Falls Church, Va.</b>	
23d. LOCATION (City, town or county) _____ (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons</b> ADDRESS <b>3501 14th St., NW</b>			
25a. REC'D BY REGISTRAR <b>JAN 12 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Robert L. Fisher</b>			

MEDICAL CERTIFICATION

ΕΥΡΩ 3

The Clinical Center, Bethesda, Md.

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The Clinical Center, Bethesda, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Dr. Broschart notified

2

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00946			Item 7 Film 6305 1/26/62 iwk			00938			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>1 hr. 20 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5130 Conn. Ave., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Dorothy ELLEN Utz</b>					4. DATE OF DEATH <b>January 18, 1962</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/5/08 05</b>		9. AGE (In years last birthday) <b>56 53</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTING CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>A. Thomas Utz</b>					14. MOTHER'S MAIDEN NAME <b>Nellie Ribble</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Brother, David E. Utz - same as above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACEREBRAL HEMORRHAGE</b> DUE TO <b>Ruptured Aneurysm, Rt middle CEREBRAL ARTERY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>?</b> DUE TO <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>?</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>April, 1941</b> to <b>Jan. 18, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 18, 1962</b> , and that death occurred <b>1235 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>GILBERT B. RADE</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>GILBERT B. RADE</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1/18/62</b> 22d. ADDRESS <b>3900 MILITARY RD., N.W.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<b>Burial</b>		<b>JAN. 22, 1962</b>		<b>GLENWOOD CEMETERY</b>		<b>WASHINGTON, D.C.</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>Wm. E. Humphrey</b> ADDRESS <b>84321 Georgia Ave. S.W.</b>					25a. REC'D BY REGISTRAR <b>55</b> DATE <b>JAN 22 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>				

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Montgomery

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Female White

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D.C.

Washington

2130 Conn. Ave. N.W.

U.S.

White

Washington, D.C.

Female White

Female White

**00947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00939

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Miss.</u> b. COUNTY <u>Fond Du Lac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fond Du Lac</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4900 Battery Lane - Apt 314</u>				d. STREET ADDRESS <u>47 Oaklawn Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sophia Cornelius Van Pelt</u>				4. DATE OF DEATH Month Day Year <u>Jan 16 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-1899</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) <u>Miss.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT Address <u>Wm K Van Pelt (husband) Steer 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLASZCZAK</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Jan 16-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 1/16/62</u>		22b. DATE THEREOF <u>1/16/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rienzi Cemetery</u>		22d. LOCATION (City, town or country) (State) <u>Fond Du Lac, Wisconsin</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 17 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krane</u>	

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THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

CHICAGO, ILL.

REPORT OF THE PHYSICS DEPARTMENT

FOR THE YEAR 1955-1956

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00948

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00941

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>3 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>95-26 Colesville Rd.</u>				d. STREET ADDRESS <u>1118 Woodside Parkway</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Speros Anthony Versis</u>				4. DATE OF DEATH <u>Jan 27 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-1901</u>	
9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacture of construction</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Anthony Versis</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>579-01-4668</u>		17. INFORMANT <u>Helen Versis (wife)</u> Address <u>Steen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan 27-62</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/30/62</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. Wash, DC</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 30 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

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FOR 2178  
1912 JUN 19



1003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

UNKNOWN

1912-01-1003

DO

Witness: [Signature] [Signature]

The ... of ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00949

00942

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>41 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47 Bethesda</b> d. STREET ADDRESS <b>5117 Wessling Lane</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Louise Pamela Wacker</b>		<b>4. DATE OF DEATH</b> <b>January 18, 1962</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 29, 1949</b>		<b>9. AGE</b> (In years last birthday) <b>12</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D.C.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Thomas Wacker</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Stuart</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>The Medical Records, The Clinical Center, Bethesda 14, Maryland</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas Septicemia with Shock</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>48 Hours</b> <b>5 Weeks</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)												<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 8, 1961</b> to <b>January 18, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 18, 1962</b> , and that death occurred at <b>7:35 PM</b> , the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <b>J. David Heywood</b> M.D.						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>January 19, 1962</b>		<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>J. David Heywood</b>						<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/22/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Gate of Heaven Cem.</b>		<b>23d. LOCATION</b> (City, town or county) <b>Silver Spring, Maryland</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey, Bethesda, Maryland</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>AN 23 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Hanes</b>					

00000

(M)

(1)

Robert A. Humphrey, Bethesda, Maryland

Date of Death: 1/22/52

Place of Birth: Silver Spring, Maryland

J. David Humphrey

Institution of Health: Bethesda, Md.  
The Clinical Center, National  
Institutes of Health

January 12, 1952

7:35 P.M.

January 12, 1952

out of hospital

on 1/11/52

None

The Clinical Center, Bethesda, Md.  
The Medical Center, National  
Institutes of Health

James H. Humphrey

None

James H. Humphrey

None

None

None

January 12, 1952

Bedroom

in bed

Bedroom

City of Washington

The Clinical Center, Bethesda, Md.

Emergency

Bedroom

Bedroom

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #2-Film G305-1/21/62-mmb

CERTIFICATE OF DEATH

Reg. Dist. No. 00943

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Me.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>58 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lycamore Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> (First) <u>Wagner</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>Jan</u> <u>15</u> <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22 1895</u>
9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11c. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Ada Dell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Lavinia E. Wagner</u>		Address <u>10519 Wayland St. Kensington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (Viral) at base</u> 500X DUE TO <u>Acute Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/19/62</u> 19 <u>62</u> , to <u>1/15/62</u> 19 <u>62</u> , that I last saw the deceased alive on <u>1/14/62</u> 19 <u>62</u> , and that death occurred at <u>6:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u>		ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse MD</u>		DATE SIGNED <u>1/15/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 17, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. NW. D.C.</u>	
24a. REC'D BY REGISTRAR <u>JAN 17 1962</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PREVIOUS ILLNESS _____		MEDICAL OPINION _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN lb <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monrovia</b> d. STREET ADDRESS <b>10x.2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Robert</b> Last <b>Gwinn Walker</b>		4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1962</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1885</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>x.2</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>United States</b>		
13. FATHER'S NAME <b>John L Walker</b>		14. MOTHER'S MAIDEN NAME <b>Harriet A Hobbs</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown No</b>		16. SOCIAL SECURITY NO. <b>Unknown None</b>		17. INFORMANT Address <b>Hospital Records above</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis, left side</b> DUE TO <b>Arteriosclerosis, cerebral vessels</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>acute lobular pneumonia, bilateral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute lobular pneumonia, bilateral</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 30, 1962</b> to <b>Jan 6, 1962</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Jan 6, 1962</b> and that death occurred at <b>3:00</b> M. from the causes and on the date stated above.						
22a. SIGNATURE <b>M. McKendree Boyer</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <b>Damascus, Md.</b>		22b. DATE SIGNED <b>1/6/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 9, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Meth.</b>		23d. LOCATION (City, town or county) (State) <b>Browningsville, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Wicks</b>		ADDRESS <b>Damascus, Md.</b>		25e. REC'D BY REGISTRAR DATE <b>JAN 9 '62</b>		
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		



1955

Montgomery

City

7 days

Johnny

Montgomery General Hospital

John

Robert Quinn  
Raymond

Robert

January 5

52

White

July 22, 1955

Walter Farm Laborer

John

Robert

Robert

John

Montgomery

Montgomery General Hospital

above

Robert Quinn, left in 1955  
Robert Quinn, right in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955

Robert Quinn, left in 1955



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00945

00952

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>8 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> d. STREET ADDRESS <b>10 EAST DIAMOND AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>WILLIAM HUGHES WALKER</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>1 24 19 62</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8/27/01</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOISTING ENGINEER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>EASTERN HARD WALL</b>	<b>9. AGE</b> (In years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>NATHAN A. WALKER</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>FRANCES WILLIS HUGHES</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>HOSPITAL RECORDS</b>	
<b>17. INFORMANT</b> <b>Address</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED VARICES IN ESOPHAGUS</b> DUE TO (b) <b>PORTAL CIRRHOSIS OF LIVER</b> DUE TO (c) <b>581.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour .m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from 7:45A to 19, to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 7:45A M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>A. D. Bonifant</b>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A. D. BONIFANT, M.D.</b>		<b>22d. ADDRESS</b> <b>SANDY SPRING, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>	<b>23b. DATE THEREOF</b> <b>1-27-62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Monacacy</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Seallsville, Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ernest C. Gartner, Gaithersburg, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 26 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Cirius S. Kraus</b>			



00052

MONTGOMERY HOSPITAL

OLNEY 8 DAYS

MONTGOMERY HOSPITAL

WILLIAM HUBERT

MALE WHITE

REGISTERED ENGINEER EASTERN HARDWARE

NATHAN A. ALDER

HOSPITAL RECORDS

FRANCIS A. HUBERT

A. D. HUBERT, M.D.

ZANDY SPRING, MARYLAND

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be filled in by the attending physician and completely filled in by the funeral director. Part 2 may be filled in by the funeral director. Part 3 should be filled in by the funeral director. Part 4 should be filled in by the funeral director. Part 5 should be filled in by the funeral director. Part 6 should be filled in by the funeral director. Part 7 should be filled in by the funeral director. Part 8 should be filled in by the funeral director. Part 9 should be filled in by the funeral director. Part 10 should be filled in by the funeral director. Part 11 should be filled in by the funeral director. Part 12 should be filled in by the funeral director. Part 13 should be filled in by the funeral director. Part 14 should be filled in by the funeral director. Part 15 should be filled in by the funeral director. Part 16 should be filled in by the funeral director. Part 17 should be filled in by the funeral director. Part 18 should be filled in by the funeral director. Part 19 should be filled in by the funeral director. Part 20 should be filled in by the funeral director. Part 21 should be filled in by the funeral director. Part 22 should be filled in by the funeral director. Part 23 should be filled in by the funeral director. Part 24 should be filled in by the funeral director. Part 25 should be filled in by the funeral director. Part 26 should be filled in by the funeral director. Part 27 should be filled in by the funeral director. Part 28 should be filled in by the funeral director. Part 29 should be filled in by the funeral director. Part 30 should be filled in by the funeral director. Part 31 should be filled in by the funeral director. Part 32 should be filled in by the funeral director. Part 33 should be filled in by the funeral director. Part 34 should be filled in by the funeral director. Part 35 should be filled in by the funeral director. Part 36 should be filled in by the funeral director. Part 37 should be filled in by the funeral director. Part 38 should be filled in by the funeral director. Part 39 should be filled in by the funeral director. Part 40 should be filled in by the funeral director. Part 41 should be filled in by the funeral director. Part 42 should be filled in by the funeral director. Part 43 should be filled in by the funeral director. Part 44 should be filled in by the funeral director. Part 45 should be filled in by the funeral director. Part 46 should be filled in by the funeral director. Part 47 should be filled in by the funeral director. Part 48 should be filled in by the funeral director. Part 49 should be filled in by the funeral director. Part 50 should be filled in by the funeral director. Part 51 should be filled in by the funeral director. Part 52 should be filled in by the funeral director. Part 53 should be filled in by the funeral director. Part 54 should be filled in by the funeral director. Part 55 should be filled in by the funeral director. Part 56 should be filled in by the funeral director. Part 57 should be filled in by the funeral director. Part 58 should be filled in by the funeral director. Part 59 should be filled in by the funeral director. Part 60 should be filled in by the funeral director. Part 61 should be filled in by the funeral director. Part 62 should be filled in by the funeral director. Part 63 should be filled in by the funeral director. Part 64 should be filled in by the funeral director. Part 65 should be filled in by the funeral director. Part 66 should be filled in by the funeral director. Part 67 should be filled in by the funeral director. Part 68 should be filled in by the funeral director. Part 69 should be filled in by the funeral director. 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VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00953										
00946										
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Virginia					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY in 1b 45 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert Hume Wanless					4. DATE OF DEATH January 17, 1962					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1911		9. AGE (In years last birthday) 50 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Wanless					14. MOTHER'S MAIDEN NAME Lotta Engstrom					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Unknown					16. SOCIAL SECURITY NO. 338 01 8586		17. INFORMANT WIFE: Mrs. Mary Jayne Wanless, Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) adeno carcinoma, pancreas 5-6 mcs. INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from Dec. 3, 1961 to Jan. 17, 1962, that (X) (we) last saw the deceased alive on Jan. 17, 1962, and that death occurred at 10:00 AM on the causes and on the date stated above.										
22a. SIGNATURE Larry J. Hines					22b. DATE SIGNED January 17, 1962					
22c. PHYSICIAN'S NAME (Type) LARRY J. HINES, CDR MC USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-19-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Fitzgeralds Funeral Home					25a. REC'D BY REGISTRAR DATE JAN 19 '62		25b. REGISTRAR'S SIGNATURE Wm. S. Hines			

00852

Memorandum

Subject: (None)

U. S. Naval Hospital

Address

Charleston

Medical Naval Officer

Harry Venable

Unknown

Virginia

Wilmington

1000 Hyman Drive

Wilmington

July 6, 1941

Wilmington

Wilmington

July 6, 1941

X

LARRY J. HINES, CDR MC USN

U. S. Naval Hospital, Boston, MA

Wilmington, Virginia

Wilmington, Virginia

Wilmington, VA

Wilmington, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00954  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery County, Md.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital Assoc. Inc.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Germantown</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mildred L. (Clagett)</b>				4. DATE OF DEATH <b>WARD</b> <b>1. 31. 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1. 2. 91</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN E. GLAGETT.</b>				14. MOTHER'S MAIDEN NAME <b>FRANCES BEAL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NONE</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Spencer Ward</b>				Address <b>Same Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>coronary atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension &amp; CVA</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1960</b> to <b>1/31/1962</b> that (I) (we) last saw the deceased alive on <b>1/31/1962</b> and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Stephen Jones</b>				22b. DATE SIGNED <b>1/31/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Stephen Jones</b>				22d. ADDRESS <b>809 Veirs Mill Rd. Rockville.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 4, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Darnestown</b>		23d. LOCATION (City, town or county) (State) <b>Darnestown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>				25a. REC'D BY REGISTRAR <b>1331 East Montgomery Ave. Rockville Md.</b>			
25b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>				DATE <b>FEB 5 '62</b>			

(M)

(1)

Spokane Hospital Assoc. Inc.

Financial A. (1910-1911)

Income

Spokane Hospital Assoc. Inc.

Dr. E. E. Jones

Dr. E. E. Jones



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00955

00948

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>9 mo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13100 Parkland Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joyce Maxine Warner</u>				4. DATE OF DEATH <u>Jan 12 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-1929</u>	
9. AGE (in years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk typist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>F.B.I.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William N. Ritenour</u>				14. MOTHER'S MAIDEN NAME <u>Martha P. Jack</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>204-22-7087</u>			
17. INFORMANT <u>Warner</u> Address <u>Stem 2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> DUE TO (b) <u>bullet wound thru skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru skull</u>			
20c. TIME OF INJURY Month, Day, Year <u>1-12-62</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Rockville</u> (County) <u>montg</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschatt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschatt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-12-62</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-16-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>				22d. LOCATION (City, town, or country) <u>Arlington</u> (State) <u>Virginia</u>			
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				24a. REC'D BY REGISTRAR <u>Jan 17 '62</u>			
Address <u>434 Georgia Ave. Silver Spring, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>			

1955

MC

WALKER

1-16-54

Frank T. Walker

Frank T. Walker

Frank T. Walker, 1000 Silver Spring, N. W. Washington, D. C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)																																															
a. COUNTY MONTGOMERY						b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY						c. LENGTH OF STAY IN 1b 7 DAYS						a. STATE MARYLAND						b. COUNTY MONTGOMERY																																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL												d. STREET ADDRESS WATERS ROAD												e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) JULIAN BOYD WATERS												4. DATE OF DEATH 1 31 19 62																																															
5. SEX MALE				6. COLOR OR RACE WHITE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9-10-78				9. AGE (In years last birthday) 83 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.																																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Farmer												10b. KIND OF BUSINESS OR INDUSTRY Farming												11. BIRTHPLACE (State or foreign country) MARYLAND												12. CITIZEN OF WHAT COUNTRY? U. S. A.																							
13. FATHER'S NAME HORACE WATERS												14. MOTHER'S MAIDEN NAME MARY E. <del>WATERS</del> Etichson																																															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No												16. SOCIAL SECURITY NO. Yes Unknown												17. INFORMANT HOSPITAL RECORDS																																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia, Bilateral</i> 9 03.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Fracture 4-5-6-10-11-12 Dorsal spine</i> (c) <i>Fracture 7th rib</i> 19 days												INTERVAL BETWEEN ONSET AND DEATH 2 days																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Cirrhosis of liver</i>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on floor in bed room at home</i>																																															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>1-12 1962</i>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>				20f. (City or town) <i>Germantown</i>				(County) <i>Montgomery</i>				(State) <i>MD</i>																															
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												DATE SIGNED <i>1-31-62</i>											
ACTUAL SIGNATURE <i>Frank J. Broschatt</i>												EXAMINER'S NAME (Type) FRANK J. Broschatt												Address (Street, city, town, or county) <i>1-31-62</i>																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF 2/2/62												22c. NAME OF CEMETERY OR CREMATORY Neelsville Cemetery												22d. LOCATION (City, town, or country) Germantown, Maryland																							
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland												24a. REC'D BY REGISTRAR DATE FEB 6 '62												24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>																																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>8 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural*- Lewisdale</b> d. STREET ADDRESS <b>RFD, Monrovia</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>J. Monroe Watkins</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>9</b> Year <b>1962</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1876</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursery Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lewisdale, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Julius M. Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Norwood</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-1533</b>		17. INFORMANT <b>Mrs Mattie Watkins, Item 2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular-Renal Disease &amp; Uremia</b> <b>442 X</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Lobular Pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>12 days</b>						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 1935</b> to <b>Jan. 9, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 9, 1962</b> , and that death occurred <b>1:30P</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>M. McKendree Boyer</b>		M.D. <b>January 10, 1962</b>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M. D.</b>		22d. ADDRESS <b>9860 Main Street, Damascus, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 11, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Methodist</b>		23d. LOCATION (City, town or county) (State) <b>Brownsville, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. McLeavorth</b>		ADDRESS <b>Damascus, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



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**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>56 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>5718 Wilson Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence Elizabeth Weeden</b>		First Middle Last		4. DATE OF DEATH <b>January 11 1962</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 November 1892</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Davis</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Buchar</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - - -</b>		17. INFORMANT Address <b>Bethesda, Maryland</b> <b>Husband William W. Weeden 5718 Wilson Lane,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Asphyxia</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Pulmonary metastases</b> DUE TO (c) <b>Carcinoma of Cervix</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>1 1/2 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While el work <input type="checkbox"/> Not While el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>17 November, 1961</b> , to <b>11 January, 1962</b> that (X) (we) last saw the deceased alive on <b>11 January, 1962</b> , and that death occurred <b>at 125 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Louis E. Potvin</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan. 12, 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>LOUIS E. POTVIN LCDR MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-13-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Page 10 of 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
00959																	
00952																	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 Months 8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>WASHINGTON</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH, D.C.</u> <u>47X-3</u> d. STREET ADDRESS <u>1006-30<sup>th</sup> ST SE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Garr</u> Last <u>White</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>1962</u>														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-11-91</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Vehicle Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit Co.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Theodore White</u>						14. MOTHER'S MAIDEN NAME <u>Sudie Davis</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>Hospital Records</u>				Address <u></u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>162.1</u> IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to Brain</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Branchogenic Carcinoma, primary</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>several months</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour <u></u> e.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>											
21. I certify that (I) (this hospital) attended the deceased from <u>10-11-1961</u> to <u>1-19-1962</u> , that (I) (we) last saw the deceased alive on <u>1-19-1962</u> and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>T.H. Lundstrom</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u></u>									
22c. PHYSICIAN'S NAME (Type) <u>T.H. LUNDSTROM, M.D.</u>						22d. ADDRESS <u>7600 Carroll Ave., Takoma Pk, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-22-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) <u>Smithland Md.</u> (State) <u></u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers G</u> ADDRESS <u>517-11<sup>th</sup> ST SE Wash DC</u>						25a. REC'D BY REGISTRAR <u></u> DATE <u>JAN 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

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STATE OF CALIFORNIA

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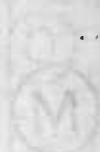
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 and fill in page 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3111 Nichols Ave., S.E.</b> d. STREET ADDRESS <b>47X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Teresa Lynn Whitenight</b>		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5 1961</b>
9. AGE (In years last birthday) <b>10</b> yrs. <b>18</b> Months <b>10</b> Days <b>18</b> Hours <b>18</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Terry Allen Whitenight</b>	
14. MOTHER'S MAIDEN NAME <b>Agnes Marion Farrell</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Agnes M. Whitenight (Mother)</b> Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration</b> DUE TO (b) <b>773.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>23 January, 1962</b> to <b>23 January, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>23 January, 1962</b> , and that death occurred <b>1330 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Fredric Schulaner</b> M.D.		22b. DATE SIGNED <b>24 January 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERIC SCHULANER LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>JAN 26 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Taltavull</b> <b>Taltavull Funeral Home 3603 14th St., N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 26 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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Director of Columbia

Washington, D.C.

1111 Michigan Ave., S.E.

January 23

Washington

10-10

March 1901

USA

England

Agent Station Paris

Mrs. Anna M. Whiting (Mother) 222 1/2

Benjamin

X

January 23 1901

January 23

24 January 1901

U. S. Naval Hospital, Bethesda, Md.

FRANKLIN COOPERMAN JR MD USN

Mr. Oliver Company

Washington, D. C.

Washington, D.C.

222 1/2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 3 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00961  
00954  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY in lb <b>74</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Fanny</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 2, 1885</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Carrol</b>				14. MOTHER'S MAIDEN NAME <b>? unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				17. INFORMANT <b>Charles H. Wilson, son</b> Address <b>same as above</b>			
16. SOCIAL SECURITY NO.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 21d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above. 22a. SIGNATURE <b>Reracelle Bernier</b> 22c. PHYSICIAN'S NAME (Type) <b>Robert L. Snowden</b> 22b. DATE SIGNED <b>JAN 15 '62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/9/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, check Yes 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00962

00955

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Montgomery</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7803 Tilbury St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Neil E. Wilson</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/04</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 24 HRS. <u>14</u> Months <u>14</u> Days <u>19</u> Hours <u>52</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>G.C. Murphy Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jessie Wilson</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Niell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>095-05-4711</u>		17. INFORMANT <u>Wife Mrs. Yvette Wilson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute myocardial infarction</u> DUE TO (c) <u>coronary heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 1/2 wks</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>14 Jan</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>13 Jan</u> , 19 <u>62</u> , and that death occurred at <u>12:05 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John M. Wyman</u>		22b. DATE SIGNED <u>14 Jan 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John M. Wyman</u>		22d. ADDRESS <u>Bethesda, Maryland 1/14/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 1/17/62</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Millville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Millville, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25. REC'D BY REGISTRAR <u>Arthur L. Hines</u>	
25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00963  
00956

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY in 1b <i>1 year, 3 mo.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington San. &amp; Hosp.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington, D.C.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> d. STREET ADDRESS <i>1868 Columbia Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Jane Wintree</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>5</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-27-83</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>15</i>	11. IF UNDER 24 HRS. Hours <i>11</i> Min. <i>3</i>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		13. BIRTHPLACE (County & State, or foreign country) <i>Nat'l. Educational Va.</i>	
14. CITIZEN OF WHAT COUNTRY? <i>America</i>		15. FATHER'S NAME <i>William Wintree</i>	
16. MOTHER'S MAIDEN NAME <i>Emily Cathright</i>		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i>	
18. SOCIAL SECURITY NO. <i>-</i>		19. INFORMANT <i>Sanitarium medical Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> DUE TO (b) <i>"Stroke" - CVA.</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <i>Cerebral Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>1 1/3 yrs</i> <i>Years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1960</i> to <i>Jan 5, 1962</i> , that (I) (we) last saw the deceased alive on <i>Jan 5, 1962</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert A. Hare</i> M.D.		22b. DATE SIGNED <i>1/6/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert A. Hare MD</i>		22d. ADDRESS <i>7600 Carroll Ave., T.P., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>1-9-1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gaudin Amos, Jr.</i>		25. REC'D BY REGISTRAR <i>Arthur S. Hines</i>	
25a. ADDRESS <i>1756 Pa Ave, NW</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

03233

Mac L. D. Mac L.

1-2-1962 Cedar Hill Elementary, Portland, ME



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>804 Maplewood Ave.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara Lucille WITZKE</u> First Middle Last DATE OF DEATH <u>1 7 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-15-00</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nebraska</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emil C. Witzke</u>		14. MOTHER'S MAIDEN NAME <u>Julia E. Hardt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT Address</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage - R hemisphere</u> <u>331X</u> DUE TO (b) <u>Cerebral arteriosclerosis and Hypertension</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>yes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH 12/4 - yes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/29/1961</u> , 19 <u>61</u> , to <u>1-7</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-7</u> , 19 <u>62</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thos H. Wolohan MD</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thos H. Wolohan</u>		22d. ADDRESS <u>7600 Carroll Ave Silver Spring MD</u>	

23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN 9, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ADELPHI. PR. GEO. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Staley</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

(M)

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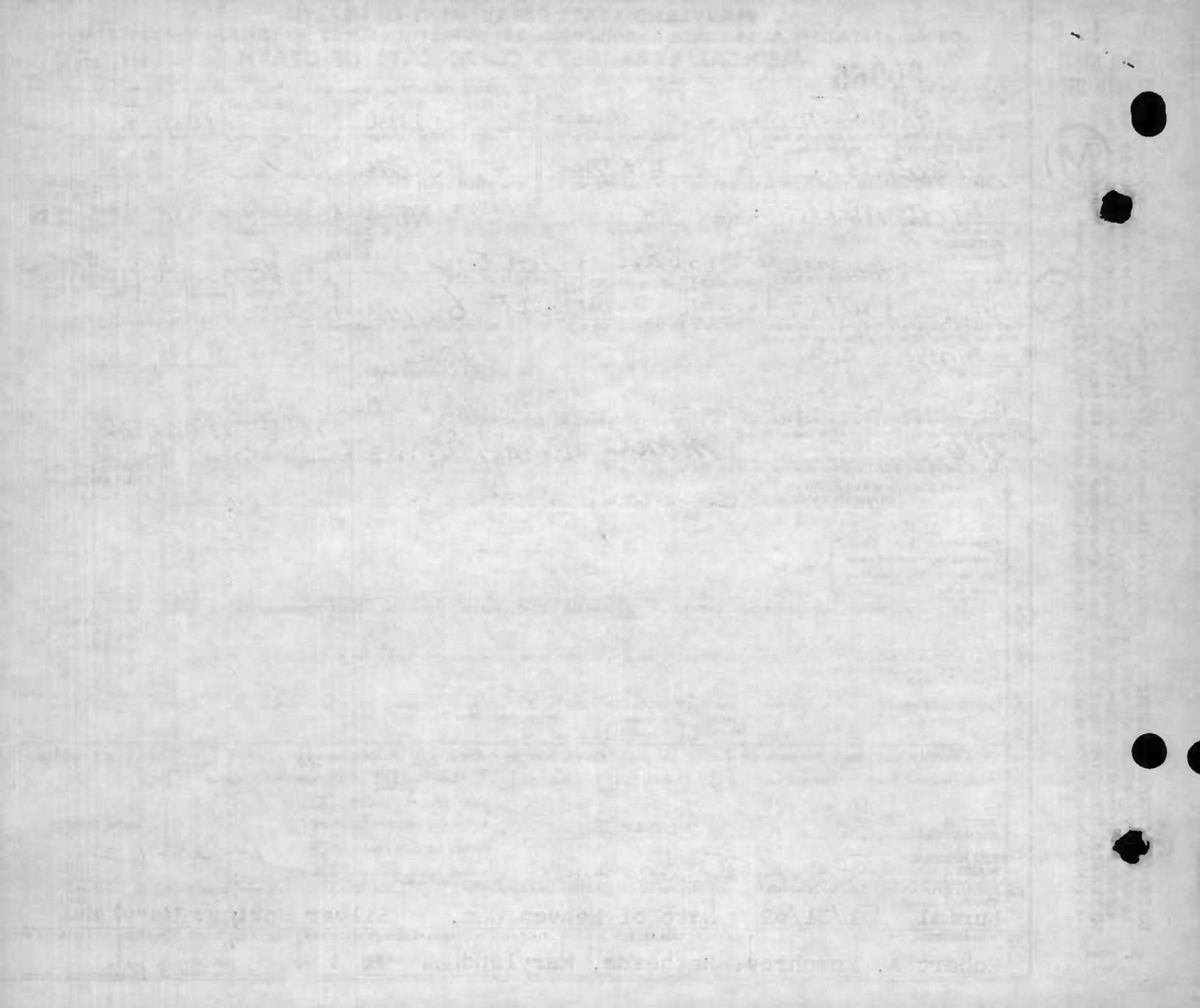
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00965  
MONTGOMERY  
BETHESDA  
8102 Maple Ridge Rd  
Francis Donovan Wolter  
Female white  
Housewife  
Richard C. Donovan  
No  
18. CAUSE OF DEATH  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 420.1 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒  
Address (Street, city, town, or county)  
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
22b. DATE THEREOF 1/31/62  
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.  
22d. LOCATION (City, town, or country) (State) Silver Spring, Maryland  
23. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey, Bethesda, Maryland  
24a. REC'D BY REGISTRAR DATE FEB 1 '62  
24b. REGISTRAR'S SIGNATURE Arthur E. Thomas

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8102 Maple Ridge Rd</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 Bethesda</u>	
3. NAME OF DECEASED (Type or print) <u>Francis Donovan Wolter</u>		d. STREET ADDRESS <u>18102 Maple Ridge Rd</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 6 1904</u>	
9. AGE (in years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Richard C. Donovan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Shields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Richard Donovan</u>		Address <u>1305 17th St. N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 72 hours after death be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Illinois</b> b. COUNTY <b>Springfield</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1722 South 11th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bessie Marie Yates</b>		4. DATE OF DEATH Month Day Year <b>January 9 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 1, 1890</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Sanders</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Jenkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>332-01-8032</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4-33- Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Aspiration of Gastric Contents</b> DUE TO (c) <b>Paroxysmal Abrial Tachycardia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1/2 Hour</b> <b>1/2 Hour</b> <b>24 Hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 13 1961</b> to <b>January 9, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 9, 1962</b> , and that death occurred at <b>10:55 PM</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Robert H. Wilkins</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>1-10-62</b> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Wilkins, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>1/11/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brush Creek Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Divernon, Illinois</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

(M)

(1)

Monography

Rehearsal

28 days

Springfield

Illinois

The Clinical Center, Bethesda, Md., 14

1952 South Irish Street

London

White

Yates

January 2

82

White

November 1, 1950

Illinois

None

No results

Charles Sanders

Ritchie's Journal

The Medical Record

334-01

The Clinical Center, Bethesda, Md., Maryland

Genetic Material

Examination of Genetic Material

Preparation of Genetic Material

Sp. 1000

X

January 2

10:35 PM

December 19 of January 2, 1952

X 1-10-52

The Clinical Center, National Institutes of Health, Bethesda, Md., 14

Robert H. White, M.D.

White

Brain and Nervous System

The S. H. Kline Company, Washington, D. C.

Examination of Genetic Material



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or attending physician, the certificate may be completed by the hospital or attending physician. If the deceased was not in the hospital or attending physician, the certificate may be completed by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00967

00960

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>ARLINGTON</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>2111 16th Street, N.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Ellis Asby Yost</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>January 7 1962</u>		<b>9. AGE</b> (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>December 12, 1872</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u>			
<b>13. FATHER'S NAME</b> <u>Wesley Yost</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Eleana Ammons</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u>		<b>16. SOCIAL SECURITY NO.</b> <u>384-10-7328</u>		<b>17. INFORMANT</b> Address <u>Washington Sanitarium + Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>450.00</u> DUE TO (b) <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>2 days.</u> <u>? years</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 6, 1957</u> <b>to</b> <u>Jan 7, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 6, 1962</u> <b>and that death occurred at</b> <u>4:55 a.m.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Robert A. Hare</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert A. Hare M.D.</u>		<b>22b. DATE SIGNED</b> <u>Jan 7, 1962</u>			
<b>22d. ADDRESS</b> <u>7600 Carroll Ave. T.P., Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>1/10/1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Washington</u>		<b>23e. (State)</b> <u>D. C.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Hare</u>		<b>24a. ADDRESS</b> <u>3901 N. Fairfax Drive</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 9 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hare</u>							

(M)

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Westerly Post

132

Robert A. Howe MD